

MEDICARE ADVANTAGE

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED TENTH CONGRESS
SECOND SESSION

—
FEBRUARY 28, 2008
—

Serial No. 110-72
—

Printed for the use of the Committee on Ways and Means



U.S. GOVERNMENT PRINTING OFFICE

46-954

WASHINGTON : 2010

For sale by the Superintendent of Documents, U.S. Government Printing Office,
<http://bookstore.gpo.gov>. For more information, contact the GPO Customer Contact Center,
U.S. Government Printing Office. Phone 202-512-1800, or 866-512-1800 (toll-free). E-mail, gpo@custhelp.com.

COMMITTEE ON WAYS AND MEANS

CHARLES B. RANGEL, New York, *Chairman*

FORTNEY PETE STARK, California	JIM MCCRERY, Louisiana
SANDER M. LEVIN, Michigan	WALLY HERGER, California
JIM MCDERMOTT, Washington	DAVE CAMP, Michigan
JOHN LEWIS, Georgia	JIM RAMSTAD, Minnesota
RICHARD E. NEAL, Massachusetts	SAM JOHNSON, Texas
MICHAEL R. MCNULTY, New York	PHIL ENGLISH, Pennsylvania
JOHN S. TANNER, Tennessee	JERRY WELLER, Illinois
XAVIER BECERRA, California	KENNY HULSHOF, Missouri
LLOYD DOGGETT, Texas	RON LEWIS, Kentucky
EARL POMEROY, North Dakota	KEVIN BRADY, Texas
STEPHANIE TUBBS JONES, Ohio	THOMAS M. REYNOLDS, New York
MIKE THOMPSON, California	PAUL RYAN, Wisconsin
JOHN B. LARSON, Connecticut	ERIC CANTOR, Virginia
RAHM EMANUEL, Illinois	JOHN LINDER, Georgia
EARL BLUMENAUER, Oregon	DEVIN NUNES, California
RON KIND, Wisconsin	PAT TIBERI, Ohio
BILL PASCRELL JR., New Jersey	JON PORTER, Nevada
SHELLEY BERKLEY, Nevada	
JOSEPH CROWLEY, New York	
CHRIS VAN HOLLEN, Maryland	
KENDRICK MEEK, Florida	
ALLYSON Y. SCHWARTZ, Pennsylvania	
ARTUR DAVIS, Alabama	

JANICE MAYS, *Chief Counsel and Staff Director*

BRETT LOPER, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH

FORTNEY PETE STARK, California, *Chairman*

LLOYD DOGGETT, Texas	DAVE CAMP, Michigan
MIKE THOMPSON, California	SAM JOHNSON, Texas
RAHM EMANUEL, Illinois	JIM RAMSTAD, Minnesota
XAVIER BECERRA, California	PHIL ENGLISH, Pennsylvania
EARL POMEROY, North Dakota	KENNY HULSHOF, Missouri
STEPHANIE TUBBS JONES, Ohio	
RON KIND, Wisconsin	

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also, published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

Advisory of February 21, 2008, announcing the hearing	Page 2
---	-----------

WITNESSES

Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services	7
James C. Cosgrove, Acting Director, Health Care Issues, U.S. Government Accountability Office	15
Byron Thames, M.D., Member, Board of Directors, American Association of Retired Persons, Orlando, Florida	108
Jim Mattes, President and CEO, Grande Ronde Hospital, La Grande, Oregon	112
David Lipschutz, Interim President and CEO, California Health Advocates, Los Angeles, California	118
Daniel C. Lyons, M.D., Senior Vice President, Government Programs, Independence Blue Cross, Philadelphia, Pennsylvania	127

SUBMISSIONS FOR THE RECORD

Association for Community Affiliated Plans, statement	155
Cathy Roberts, statement	157
Kathy Castor, statement	158
The Senior Citizens League, statement	159

MENTAL HEALTH AND SUBSTANCE ABUSE PARITY

THURSDAY, FEBRUARY 28, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:01 a.m., in Room 1100, Longworth House Office Building, Hon. Fortney Pete Stark [chairman of the subcommittee] presiding.
[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
February 21, 2008
HL-20

CONTACT: (202) 225-3943

Health Subcommittee Chairman Stark Announces a Hearing on Medicare Advantage

House Ways and Means Health Subcommittee Chairman Pete Stark (D-CA) announced today that the Subcommittee on Health will hold a hearing on the costs seniors and people with disabilities pay through the Medicare Advantage Program. **The hearing will take place at 10:00 a.m. on Thursday, February 28, 2008, in the main committee hearing room, 1100 Longworth House Office Building.** At the hearing, the Government Accountability Office (GAO) will release and discuss findings of a new report on cost-sharing changes under Medicare Advantage plans.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Of the 43 million Medicare beneficiaries, 8.8 million (20%) are enrolled in what are currently known as Medicare Advantage (MA) plans. These private health plans must provide benefits “actuarially equivalent” to those covered under traditional fee-for-service (FFS) Medicare (Parts A&B). However, Medicare Advantage plans can and often do limit the network of providers that are available to beneficiaries, and often have higher cost-sharing requirements for selected services and different premiums than traditional FFS Medicare. MA plans can provide additional benefits that are not covered by traditional Medicare, such as eyeglasses and yearly physical exams. However, some of these same plans charge higher cost-sharing for covered Medicare services.

The number of private plans available to Medicare beneficiaries and enrollment in such plans have grown steadily since 2003, as plan payments and options have increased. There are now eight different types of MA plans: Health Maintenance Organizations (HMOs); Provider Sponsored Organizations (PSOs); Preferred Provider Organizations (PPOs); Regional PPOs; Private Fee For Service Plans; Cost Contract Plans; Special Needs Plans (SNPs); and Medical Savings Account plans.

According to the Medicare Payment Advisory Commission (MedPAC), MA program payments were on average 113 percent of FFS expenditure levels in 2007. To create financial neutrality between private plan and FFS payment rates, MedPAC has recommended setting MA benchmarks equal to 100 percent of FFS. For many years, plans were paid at 95 percent of FFS rates, reflecting industry claims that private plans were more efficient. Only in recent years have payments risen to be substantially higher than local FFS payments.

“I am concerned that seniors enrolling into Medicare Advantage plans may be unaware that under certain circumstances, they may be charged more than traditional Medicare,” said Chairman Stark in announcing the hearing. **“I look forward to hearing from CMS, GAO and our other witnesses about the costs associated with Medicare Advantage plans, and the steps that the Administration is taking to ensure that these costs are accurately explained. I also think we need to get a better sense of what services plans are actually providing with the extra dollars, instead of more rhetoric**

about what is offered. It's an important distinction that deserves a full discussion."

FOCUS OF THE HEARING:

The hearing will focus on the structure, costs and oversight of the Medicare Advantage program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select "110th Congress" from the menu entitled, "Committee Hearings" (<http://waysandmeans.house.gov/Hearings.asp?congress=18>). Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the on-line instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You **MUST REPLY** to the email and **ATTACH** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Thursday, March 13, 2008**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and **MUST NOT** exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://waysandmeans.house.gov>.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. Good morning, and thank you for joining us on this hearing this morning as we review the value of Medicare

Advantage overpayments. We will commence our hearing in a moment.

We are now overpaying Medicare Advantage plans around 13 percent, on average, according to MedPAC's latest analysis. In some areas, we are overpaying them by 50 percent. The President just sent us a budget with more than half a trillion dollars in cuts to Medicare over the next decade, but none of those cuts came from Medicare Advantage. The overpayments in that budget remain firmly in place.

The President's budget also sent to Congress a legislative response to the so-called Medicare trigger. Again, the President's plan protects the special interests of the Medicare Advantage plans and puts all the costs or the cuts of meeting what I think is an irresponsible trigger policy squarely on the backs of America's seniors by increasing prescription drug premiums for millions of beneficiaries.

Clearly, the administration believes that these overpayments are warranted. We asked the GAO, the Government Accountability Office, to report back to us regarding to what extent these overpayments translate into reduced cost-sharing or extra benefits, and if any or if so, whether this is an efficient way to achieve any goals that were inherent in these reduced costs or extra benefits.

The report was requested jointly by the Committee on Ways and Means, our subcommittee, Energy and Commerce, and the Government Oversight Reform. I don't want to steal the GAO's thunder, but I think it is worth highlighting a few of the things that the report will discuss today.

First, we have no idea what beneficiaries actually receive in Medicare Advantage plans because there is absolutely no requirement that the Medicare Advantage plans turn over any data on the services actually rendered to the government or to beneficiaries. The only way GAO could analyze the different benefits was to rely on projections from the Medicare Advantage plans with respect to how they said they would spend their subsidies. That is not acceptable. That is just like no-bid contracts in Iraq. We ought to know what we are getting, and it would be a simple matter for CMS to request that data.

Second, if you look at the Medicare Advantage plans' own projections, the GAO finds that beneficiaries can spend more in a Medicare Advantage plan than they would in fee-for-service Medicare. They can spend; they don't necessarily all spend more. The services most often associated with higher co-payments are home health and hospitalizations, two services that are vital to sick people and are obviously more of a burden to low-income people. If plans successfully cherry-pick healthy seniors, which they do, and the payments are based on averages, it means we are overpaying them even more than we think.

Third, the report shows that MA plans invest 3 percent in Part B premium reductions, and that is the only improvement that is guaranteed to be valuable to every enrollee.

Fourth, the Medicare Advantage plans are far less efficient than fee-for-service Medicare, which essentially operates with a 98 percent medical loss ratio. In contrast, in the average Medicare Advantage plan, the medical loss ratio is 87 percent. But nearly one-

third of the plans have a medical loss ratio of less than 85 percent. It would be good to know how low the medical loss ratios actually go. CMS has actually refused to release that data to GAO, and my hope is that they will be able to explain why they won't release the data and perhaps change their minds.

GAO's findings raise serious questions about the value of lavishing subsidies on Medicare Advantage plans as a means to "help" Medicare beneficiaries. Today's second panel will reveal what is happening to Medicare beneficiaries in the real world as they attempt to navigate the confusing world of Medicare Advantage and the shoddy sales practices that their shyster-like sales people foist on frail and often confused Medicare beneficiaries.

Our witnesses will confirm that many Medicare beneficiaries are unaware that their costs may be higher than they would in traditional Medicare. They believe that they are enrolling in a Medigap plan under which they would never pay more, and they are shocked when they learn how much they have to pay. These issues are only a small part of the oversight needed in the Medicare Advantage plans.

I would be remiss not to highlight that the CHAMP Act, which we passed out of the House last year and is still pending in the Senate, addressed many of these concerns. It leveled the playing field on payments to Medicare Advantage plans. It required plans to meet a medical loss ratio of 85 percent to participate.

It ensured that beneficiaries wouldn't pay more in Medicare Advantage than they would in traditional fee-for-service Medicare. And it provided states with the tools they need, and the Federal Government refuses to use, to regulate marketing of Medicare Advantage plans to protect consumers.

It may sound differently, but I am not against private plans in Medicare. My district has perhaps the highest penetration of Medicare Advantage in the country. Half of the people in my district—not half of the insured, half of the people—in my district belong to Kaiser Permanente, a credible managed care plan. And they should have the choice to join that.

But the rest of us shouldn't be subsidizing the people who choose to go into Kaiser. Plans should compete on a level playing field and preserve many of the core choices that really matter to beneficiaries.

I think that managed care and multi-discipline group practice will be the medical delivery plans of the future, but I see no reason that they have to be grossly overpaid and under-regulated.

Mr. Camp?

Mr. CAMP. Well, thank you, Mr. Chairman. And what are the benefits of Medicare Advantage plans and what they provide to beneficiaries is an important question. So thank you for having this hearing. It really goes to the heart of the debate about Medicare Advantage.

Unfortunately, most of the witnesses today are going to use the highly selective data and hypothetical scenarios to draw negative conclusions about the benefits provided by Medicare Advantage plans. This stilted analysis does not reflect the experience of most Medicare Advantage enrollees or the actual value of the plans they provide.

Medicare Advantage plans provide significant savings for their enrollees compared to what is charged in traditional Medicare. According to the GAO, beneficiaries in Medicare Advantage would expect to pay \$804 less this year in out-of-pocket expenses than those in traditional Medicare.

And these findings were echoed in a recent Kaiser Family Foundation report that examined actual beneficiary health spending. The Kaiser report found that, on average, beneficiaries enrolled in Medicare Advantage coordinated care plans would save nearly \$550, and beneficiaries who use the most healthcare services would save nearly \$4,200 compared to those in fee-for-service Medicare.

Anyone who doubts that Medicare Advantage plans provide real savings to beneficiaries need only look at the rapid growth in enrollment in these plans. If beneficiaries did not see the real value in these plans, enrollment in Medicare Advantage would not have doubled since 2003, bringing total enrollment in these plans to nearly nine million beneficiaries.

Fee-for-service Medicare fails to protect beneficiaries from catastrophic healthcare costs, and often forces them to pay large deductibles and cost-sharing payments. This reality is the reason why approximately 40 percent of Medicare beneficiaries have either enrolled in Medicare Advantage or have otherwise purchased Medigap plans.

Instead of attacking programs that provide choices and quality care, we should be looking at ways to perform the traditional Medicare, which provides less. This is exactly what the Republican majority did when it created Medicare Advantage in 2003. I am disappointed by the analysis in GAO's report, which fails to reflect the real-world experience of the beneficiaries enrolled in Medicare Advantage.

In fact, GAO's report does not reflect the reality of a single beneficiary in any Medicare Advantage plan. The report only looks at hypothetical beneficiaries who use only certain types of services and enroll in a narrow selection of plans. I frankly expected more from the GAO.

At the conclusion of this hearing, I intend to send a letter to the Comptroller General asking that GAO undertake a new study. I hope this study will review the actual services used by real beneficiaries and compare that to the benefit packages of the most popular Medicare Advantage plans. I suspect that this analysis will give a much fairer and more representative view of the savings that Medicare Advantage plans provide to Medicare beneficiaries.

Critics of the program will undoubtedly use this report to attack Medicare Advantage and assert that it fails to provide real benefits to program enrollees. In doing so, they will ignore the reality that the vast majority of plans actually provide much better cost-sharing benefits. They will also ignore the fact that GAO found that half a million beneficiaries have chosen to enroll in plans that have no cost-sharing on inpatient hospital visits.

Some opponents of seniors being able to choose their healthcare instead of government believe that seniors are not smart enough to make choices about their healthcare. I fundamentally disagree, as do the 18 million seniors who have chosen Medicare Advantage and

Medigap plans, as I said, more than 40 percent of all Medicare beneficiaries.

If we give them the opportunity, seniors will choose the plan that best fits their needs and provides them with the best benefits. And if we are really concerned about seniors not getting access to the best possible cost-sharing protections, perhaps we can agree to improve the comparative data that we provide to all Medicare beneficiaries. If everyone in Medicare could see how much they could save by enrolling in Medicare Advantage, I believe that even more beneficiaries would enroll in this important program.

Thank you, and I yield back the rest of my time.

Chairman STARK. As between bureaucracies, if my friend would yield, I would like a report also about what beneficiaries receive, not what they are offered, and have asked CMS repeatedly to give us that information. They can tell you they don't have it and they don't collect it.

The GAO would love to do the report for us, and the data doesn't exist. So I would be delighted to join with my colleague to say, let's require this data. And I am not sure who would be able to better use it for their position. But the fact that we are not getting the data, I think, is that we are kind of legislating in the blind.

And I hope you would agree that we can require that data to be forthcoming, and it could be sanitized so we protect competitive advantage and that sort of thing.

Mr. CAMP. I think being able to use real data from real plans, and not hypothetical plans—this report purports to be an analysis of cost-sharing and Medicare Advantage, and it does nothing of the kind.

Chairman STARK. But let us hear from the people who have been wrestling with this. And we will start with Kerry Weems. Administrator Weems is the acting administrator for the Centers for Medicare and Medicaid Services, affectionately known as CMS, from the U.S. Department of Health and Human Services.

Why don't you proceed to enlighten us, Mr. Weems, in any way you would like.

**STATEMENT OF KERRY WEEMS, ACTING ADMINISTRATOR,
CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DE-
PARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. WEEMS. Thank you. Good morning, Mr. Chairman, Mr. Camp, members of the committee.

Mr. Stark, you said you would be delighted, so let me add to your delight today. I have directed our Center for Beneficiary Choices to begin collecting the data that you request on additional benefits. We will collect it for past benefit years.

There will probably be some data analysis that we will have to do. But going forward, we will collect the data in a regularized format so that we can all understand it. I agree with the chairman and with the ranking member. Let's have a discussion about the facts, and let's get the facts on the table. It is time to do that. I hope to be able to provide that information to this committee, to the GAO, and to others, again respecting proprietary information.

Medicare Advantage is providing an affordable, high-value choice to roughly nine million beneficiaries. In 2008, plans offer an aver-

age of over \$1,100 in additional value to enrollees beyond original Medicare. For example, plans offer such benefits as routine eye care, hearing exams, additional inpatient hospital days, reduced cost-sharing for many services, and unlike original Medicare, MA enrollees do not face separate cost-sharing for physician and ancillary services when hospitalized.

I would like to now discuss GAO's findings in their report released today, and focus on one important Medicare benefit, inpatient hospital stays. At the risk of having warring charts, I did bring some charts with me today, and I would ask the committee's indulgence as I discuss them.

If we would first turn to the one to my right, your left, this is a complex chart but I think it—

Chairman STARK. Kerry, do we have—

Mr. CAMP. I am hopeful that you do, sir.

Chairman STARK. Thank you.

Mr. CAMP. Let's start with the first column that says "One Day," and then we will focus on—for a one-day hospital stay, for a Medicare Advantage plan—I am sorry. Do we all have it? Do we have enough to go around? Thank you.

For a one-day hospital stay, the average cost-sharing for a Medicare Advantage enrollee is \$237, as opposed to \$1,108 under regular fee-for-service Medicare. And then if you take that and weight it by population, for a one-day it is \$225 as opposed to the \$1,108.

And then we show the various plans at various percentiles, the 25th percentile, the median, the 95th percentile. Even at the 95th percentile, for a one-day stay you can see that the cost-sharing is considerably less than what it is for fee-for-service Medicare.

And in fact, if you now turn to the green boxes at the bottom, you have to get to the 98th percentile of Medicare Advantage plans, and still there is lower cost-sharing. And the lower cost-sharing there is \$952.

Then weight that by enrollment, and that is the very last row. Ninety-nine percent of beneficiaries have chosen an insurance product where their inpatient hospital copay for a one-day stay is less than fee-for-service Medicare. And in fact, now taking that bottom row, you can look across and see how beneficiaries have chosen through this choice to protect themselves against catastrophic or very high cost-sharing that you can see in fee-for-service.

So take pretty close to the average—the average inpatient hospital stay is about five and a half days. So at six days, the expected Medicare cost would be about \$1,400. 87.5 percent of Medicare beneficiaries enrolled in a Medicare Advantage plan have chosen a plan which protects them against those higher costs. And then you can see how that plays out, even on very long outliers. And this is weighted by the actual plan choices that beneficiaries make.

This chart to my left, the bar chart, shows essentially the same data, but it is unweighted by beneficiary. The most telling piece, just for this one benefit, is the choices the beneficiaries have exercised to protect themselves against very high out-of-pocket costs.

So I think that lays a good foundation for our discussion today. I will stop there.

[The statement of Kerry Weems follows:]

**Testimony of
 Kerry Weems
 Acting Administrator
 Centers for Medicare & Medicaid Services
 Before the
 House Ways & Means Subcommittee on Health
 On
 The Structure and Costs of the Medicare Advantage Program
 February 28, 2008**

Good morning Chairman Stark, Ranking Member Camp and distinguished members of the Subcommittee. I am pleased to be here today to discuss the Medicare Advantage (MA) program.

MA is providing an affordable, high-value choice for all Medicare beneficiaries. Currently, MA enrollment is at an all-time high, with roughly one-in-five (9 million) Medicare beneficiaries enrolled in a MA plan. MA plans are available in every State across the country and, in large part due to improvements enacted by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), MA plans are now serving a significant number of beneficiaries in rural areas. In 2008, MA plans are offering an average of over \$1100 in additional annual value to enrollees in terms of cost savings and added benefits beyond original fee-for-service (FFS) Medicare.

Medicare Advantage Payment Overview

Under the revised payment methodology included in the MMA, plans submit bids for their projected costs to deliver Part A and Part B services in the coming year. The bids are compared to county-specific benchmarks, and adjusted to reflect the health risk characteristics of their enrollees, to determine the total payment to plans.

Benchmarks are the maximum amount Medicare will pay a particular type of plan for delivering Part A and B benefits in a specific geographic area. They are determined by the Secretary each year under a methodology provided in the Medicare law. For most plans, benchmarks are based on the county capitation rates that were used for payment purposes before the bidding system for MA plans began in 2006. Plan benchmarks are averages of county rates weighted based on projected plan enrollment in each county in a plan's service area.

The vast majority of plan bids are below their respective benchmarks. If a plan bid is above the benchmark, an enrollee must pay the difference in the form of a premium, referred to as the "basic beneficiary premium." If a plan bid is less than its benchmark, 75 percent of the difference, termed the "rebate," must be provided to enrollees as extra benefits (in the form of cost-sharing reductions, premium reductions for Part B or Part D, or additional covered services). For local plans, the remaining 25 percent of the difference is retained by the Federal Treasury. For regional preferred provider organization (PPOs), 12.5 percent of the difference is retained by the federal treasury and the remaining 12.5 percent is directed to the MA Regional Plan Stabilization Fund.

In March 2007 MedPAC reported that payments to MA plans in 2006 were on average 12 percent higher than estimated federal costs if the MA enrollees were still in FFS Medicare.¹ As CMS testified in 2007, there are a number of important factors to keep in mind when considering the payment differential presented by such analyses. These differentials exist because of an interest by policymakers to ensure that payments were high enough in low per-capita-cost areas to provide beneficiaries in those areas with private plan options. Representatives of regions with low per-capita costs argued that otherwise the beneficiaries in their areas were being disadvantaged just because their areas were low cost. The policies in place now have achieved the goal of broad access to private plans, and have also resulted in lessening the variation between the high and low-cost regions. The ratio between the highest and lowest county payment rate was 5.47 in 1997 and is now 2.29 (for 2008).

Focusing on aggregate MA payment differentials over-simplifies the issue by not acknowledging regional variations in FFS costs. We know that there is wide geographic variation in average FFS costs. While average MA payments nationwide may exceed average nationwide FFS costs by 12 or 13 percent, the actual differential varies considerably across the country. Differentials tend to be highest in areas where average FFS costs and MA payments are the lowest – often rural areas. Differentials are lowest, or close to zero, in areas where average FFS costs and MA

¹ MedPAC will issue an update on March 1, 2008. Based on the December 2007 MedPAC meeting, the new projected differential is expected to be 13 percent for 2008.

payments are the highest. For example, in 2007, average MA plan payments in La Crosse, WI, exceeded average FFS costs in the area by 41 percent. In the higher-cost Dade, FL area, however, the average MA plan payments was actually 2 percent less than average FFS costs. Looking at the differences in payment between La Crosse and Dade counties alone (41 percent and -2 percent, respectively), might lead someone to conclude that plans in Dade are far more efficient than plans in La Crosse. In La Crosse, the average risk-adjusted FFS cost is just \$412. In Dade it is more than double, at \$1062. It is incorrect to suggest that plans in La Crosse are less efficient based on a comparison of their payment rates to dramatically lower risk-adjusted FFS costs.

The Value of Medicare Advantage

Competition in the MA program has created significant value for beneficiaries. For example, MA enrollees typically benefit from reduced cost-sharing relative to FFS Medicare; all regional PPO enrollees have the protection of a required catastrophic spending cap and a combined Part A and B deductible. In addition:

- 67 percent of plans have coverage for eye glasses;
- 83 percent have coverage for routine eye exams;
- 86 percent cover additional inpatient acute care stay days; and
- 90 percent waive the 3-day hospital stay requirement for Skilled Nursing Facility care.

In 2008, enrollees in MA plans are receiving, on average, additional benefits, including lower cost-sharing, with a value of \$96 per month. MA plans restructure and reduce average cost-sharing relative to FFS Medicare. Many MA plan enrollees also receive basic Part D prescription drug coverage at a lower cost than stand-alone Part D plans (PDPs) can provide. Enrollees in MA plans that include Part D coverage (MA-PDs) save money on drug coverage in two ways. First, MA plan drug premiums for basic coverage in 2008 were, on average, about six dollars less than average PDP premiums for basic coverage. Second, the MA payment structure allows MA-PDs to use rebates to further reduce Part D premiums. On average, Part D premium savings from rebates was more than \$16 per month in 2008.

Additionally, unlike with FFS Medicare, MA enrollees do not face the physician and ancillary services cost-sharing associated with a hospital stay separately. These costs are bundled with the hospital out-of-pocket cost-sharing. What is more, many plans have additional coverage in the form of maximum out-of-pocket limits for inpatient stays.

We do acknowledge the Subcommittee's previously expressed interest in data regarding the utilization of additional benefits by plan enrollees. We do not currently collect comprehensive utilization data on all MA benefits. However, MA enrollees do report on their perception of the experience in MA plans through the Consumer Assessment of Health Plan Survey (CAHPS). Scores from CAHPS are consistently high. Eighty-six percent of respondents give their plan a rating of 7 or higher (on a scale of 10). Ninety percent of respondents indicated that they usually or always received needed care. Eighty-eight percent of respondents indicated that they usually or always received care quickly.

Oversight of MA Plans

With respect to CMS oversight of MA plans, I want to indicate my unequivocal commitment to protecting people with Medicare from potential marketing abuses and to ensuring that beneficiaries have the information they need to make informed choices about their health care. Since September 2007, when I began my tenure as Acting Administrator, I have made it a top priority for CMS to be more proactive and transparent than ever before in overseeing the MA program, and we have made significant strides in strengthening program oversight.

Greater transparency allows beneficiaries, you in the Congress, and all interested parties to have a clearer awareness of our ongoing oversight activities, the nature of any plan violations, and the actions we take to remedy them. In November 2007, for example, we implemented a star-rating system for MA plans that expanded on the existing rating system for prescription drug plans. This Web-based tool provided the public with a powerful new way to comparison shop MA plans during the 2007 open enrollment period. In the past month, we refined our approach to posting Corrective Action Plans (CAPs) on the CMS Web site, making the information on CAPs more accessible and understandable for beneficiaries and others.² CMS has posted summary

² <http://www.cms.hhs.gov/MCRAdvisPartDEandData/CAP/>

enforcement action information to the Web as well, such as information on intermediate sanctions and civil monetary penalties (CMPs) levied against plans.³ We believe that all of these efforts toward increased transparency are shaping MA plan behavior in the ways that we had hoped. For example, in a recent meeting with a sanctioned MA plan, the plan's senior officials cited the public posting of CMPs as a significant concern due to its impact on how existing and potential enrollees view the plan. In other words, plans are taking CMS oversight very seriously.

We have strengthened our oversight and enforcement tools through a variety of measures aimed at holding MA plans – and, because of the relative “newness” and rapid growth of this option, private-fee-for-service (PFFS) plans in particular – responsible for their marketing practices and the conduct of their agents and brokers. In December 2007 we published a Final Rule clarifying and modifying compliance requirements for MA and prescription drug plans.⁴ For example, under the new Final Rule, we are streamlining the process of imposing intermediate sanctions and CMPs, by eliminating the informal reconsideration process that had significantly delayed CMS action and our ability to make compliance actions public in the past, among other actions. We also have made clear in the Final Rule that appealing plans bear the burden of proof when challenging an adverse contract determination.

Furthermore, CMS continues to seek ways to address concerns related to marketing of MA plans, including PFFS and SNPs, that limit the ability of plans to pressure beneficiaries into certain products (in addition to the special enrollment period for beneficiaries who have been pressured or deceived into enrolling in a plan). We also hope to improve information sharing between MA organizations and State Medicaid agencies and have stepped up our routine communication with our Office of Inspector General and the Department of Justice to ensure coordination on matters that ultimately may require law enforcement oversight or investigation.

³ http://www.cms.hhs.gov/MCRAdyPArtdEnrolData/Downloads/Enforcement_Actions_Web.pdf

⁴ CMS-4124-FC, 72 Fed. Reg. 68700, Dec. 5, 2007.

I intend to continue using all of the enforcement tools at my disposal, along with continued transparency, to protect beneficiaries from harmful marketing practices and other program violations to the best of our ability for the remainder of my tenure as Acting Administrator.

Finally, we are aware of Government Accountability Office's ongoing work to examine additional benefits in the MA program, and would like to highlight some methodological concerns with their analysis. The draft report shared with CMS describes the type and value of additional benefits, including lower cost-sharing that beneficiaries receive when they choose a Medicare Advantage plan. It compares the level of additional value that health maintenance organizations (HMOs), PPOs, and PFFS, plans offer beneficiaries. Instead of highlighting the value of these additional benefits, and how they vary by plan type, the authors chose to highlight that some MA enrollees are exposed to higher inpatient hospitalization cost sharing. The methodology used to determine inpatient cost sharing was flawed in that it did not include Part B services, consider longer term hospitalizations, or address effective out-of-pocket maximums. This finding was then used to create a general impression that MA plans do not usually reduce all types of out-of-pocket costs for beneficiaries with their rebate dollars. Overall, CMS finds the information in the GAO report confirms that the MA program is working as Congress intended. It is providing broad access to a valuable alternative to FFS Medicare.

Conclusion

Mr. Chairman, thank you again for this opportunity to speak with you today. We look forward to working with Congress to further strengthen the MA program, which is offers important choices to all beneficiaries, including those in rural areas who historically have not had choices. The system offers, enhanced benefits and access to high quality care for approximately 20 percent of the Medicare population, and is a particularly important option for those who lack access to retiree coverage or other supplemental coverage through Medicaid or a private supplement policy. I would be happy to answer any of your questions.

Chairman STARK. Okay. We can continue this in our inquiry.

And I would now turn to James Cosgrove, who is the acting director of healthcare issues—do you direct the issues or the department that looks at the issues—at the GAO. And I guess you have to suffer as the author of this. Right?

Mr. COSGROVE. I wouldn't say I suffered. I think my team worked long hours to put it together. So maybe they suffered.

Chairman STARK. All right. Well, why don't you expand on the report, which we have all had a chance to at least see a summary of, and enlighten us in any manner you choose.

**STATEMENT OF JAMES C. COSGROVE, ACTING DIRECTOR,
HEALTHCARE ISSUES, U.S. GOVERNMENT ACCOUNTABILITY
OFFICE**

Mr. COSGROVE. Thank you, Mr. Chairman and Ranking Member Camp and members of the subcommittee. I am pleased to be here today to discuss our findings on cost-sharing and additional benefits in Medicare Advantage plans.

In 2006, Medicare paid \$59 billion to plans, which was an estimated \$7.1 billion more than would have been spent if plan enrollees had instead received care through the fee-for-service program. So an important question is: What do beneficiaries and taxpayers get for this additional spending? Our report and my testimony today attempts to shed some light on this issue.

Our findings largely pertain to the rebates that plans received. As you know, plans submit bids for providing Medicare covered services. Plans that bid less than established amounts receive rebates up to 75 percent of the difference. And plans must use those rebates to reduce cost-sharing, reduce premiums, or add benefits.

Because the benchmarks are set relatively high, plans may submit bids that exceed fee-for-service spending and still receive substantial rebates. Plans may also charge beneficiaries a premium and use that money to reduce cost-sharing or add benefits.

In our report being released today, we analyzed how plans projected they would spend the rebates and premiums they received in 2007. As has already been discussed this morning, these are plan projections because the data currently do not exist to know how plans actually spent the money or the services that they actually provided.

Nearly all the plans in our study received a rebate, which averaged \$87 per member per month. And on average, plans projected allocating their rebates as follows: 69 percent to reduce beneficiary cost-sharing; 20 percent to reduce premiums; and 11 percent to add some coverage for benefits that are not provided under traditional fee-for-service.

For example, plans projected spending about \$4 per member per month on some dental care. Plans projected spending lesser amounts on other types, such as vision care or health education.

Because Medicare pays significantly more for Medicare Advantage beneficiaries and plans project using much of that additional money to reduce cost-sharing, it is no surprise that, on average, plans' overall expected cost-sharing is relatively low. However, we found that beneficiaries in some plans could pay much more for certain important services than they would have paid if they had remained in fee-for-service.

And this is because plans are allowed, within limits set by CMS, to establish their own cost-sharing requirements. So, for example, about 19 percent of Medicare Advantage enrollees were in plans that required cost-sharing for home health services. In contrast, beneficiaries in the traditional fee-for-service program pay nothing for that care.

We also found that beneficiaries in some plans could face expensive cost-sharing for inpatient services depending on how long they were hospitalized. So, for example, as our chart shows, some plans charge \$275 or more for the first ten days of care. This is an example of one plan, but there were 15 or 16 other plans like it.

In fact, there were 80 plans that charged more than \$200 a day, some as much as \$375 a day. Some charged for more than ten days of care. Of the 80 plans, they enrolled half a million beneficiaries. Many of these plans had maximum out-of-pocket limits, but many of these plans also had maximums that excluded certain services.

As our chart also shows and as Mr. Weems has pointed out, beneficiaries in those same plans might pay relatively less for either short hospital stays or extremely long ones. Nearly half the plans we reviewed projected using some of their rebates to limit beneficiaries' annual out-of-pocket spending for cost-sharing. But as I just mentioned, many plans excluded certain services from those maximums; for example, physician specialists, mental healthcare, outpatient substance abuse treatment, home health services, prosthetics, and durable medical equipment.

So in closing, it is important to remember that there is no free lunch when it comes to Medicare Advantage. Any reductions in cost-sharing or premiums and any increases in benefits have largely been made possible only through the infusion of billions of extra dollars into the Medicare Advantage program.

These extra dollars have resulted in a greater burden on taxpayers and higher Part B premiums for all beneficiaries, including those in the fee-for-service program. And in spite of these extra dollars, some beneficiaries may face higher cost-sharing for important services.

As Congress considers the design and the cost of the Medicare Advantage program, it is important to remember to balance the needs of all beneficiaries and ensure the program is sustainable.

Mr. Chairman, this concludes my prepared remarks. I am certainly happy to respond to any questions that you or other members might have.

[The statement of James C. Cosgrove follows:]

**Statement of James C. Cosgrove, Acting Director, Health Care Issues,
U.S. Government Accountability Office**

GAO	United States Government Accountability Office <hr/> Testimony Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives
------------	---

For Release on Delivery
Expected at 1000 a.m. EST
Thursday, February 28, 2008

MEDICARE ADVANTAGE

**Higher Spending Relative to
 Medicare Fee-for-Service
 May Not Ensure Lower
 Out-of-Pocket Costs for
 Beneficiaries**

Statement of James Cosgrove, Acting Director
Health Care





Why GAO Did This Study

Although private health plans were originally envisioned in the 1990s as a potential source of Medicare savings, such plans have generally increased program spending. In 2000, Medicare paid \$50 billion to Medicare Advantage (MA) plans—an estimated \$7.1 billion more than Medicare would have spent if MA beneficiaries had received care in Medicare fee-for-service (FFS).

MA plans receive a per member per month (PMPM) payment to provide services covered under Medicare FFS. Almost all MA plans receive an additional Medicare payment, known as a rebate. Plans use rebates and sometimes additional beneficiary premiums to fund benefits not covered under Medicare fee-for-service, reduce premiums, or reduce beneficiary cost sharing. In 2007, MA plans received about \$8.3 billion in rebate payments.

This testimony is based on GAO's report, *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs* (GAO-09-0271, February 2009). For this testimony, GAO examined MA plans' (1) projected allocation of rebates, (2) projected cost sharing, and (3) projected revenues and expenses. GAO used 2007 data on MA plans' projected revenues and covered benefits, accounting for 71 percent of beneficiaries in MA plans.

To view the full product, including the scope and methodology, click on GAO-09-0271. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

February 25, 2009

MEDICARE ADVANTAGE

Higher Spending Relative to Medicare Fee-for-Service May Not Ensure Lower Out-of-Pocket Costs for Beneficiaries

What GAO Found

GAO found that MA plans projected they would use their rebates primarily to reduce cost sharing, with relatively little of their rebates projected to be spent on additional benefits. Nearly all plans—91 percent of the 2,065 plans in the study—received a rebate. Of the average rebate payment of \$87 PMPM, plans projected they would allocate about \$76 PMPM (89 percent) to reduced cost sharing and reduced premiums and \$10 PMPM (11 percent) to additional benefits. The average projected PMPM costs of specific additional benefits across all MA plans ranged from \$0.11 PMPM for international outpatient emergency services to \$4 PMPM for dental care.

While MA plans projected that, on average, beneficiaries in their plans would have cost sharing that was 42 percent of Medicare FFS cost-sharing estimates, some beneficiaries could have higher cost sharing for certain service categories. For example, some plans projected that their beneficiaries would have higher cost sharing, on average, for home health services and inpatient stays, than in Medicare FFS. If beneficiaries frequently used these services that required higher cost sharing than Medicare FFS, it was possible that their overall cost sharing was higher than what they would have paid under Medicare FFS.

Out of total revenues of \$783 PMPM, on average, MA plans projected that they would allocate about 87 percent (\$683 PMPM) to medical expenses. MA plans projected they would allocate, on average, about 9 percent of total revenue (\$71 PMPM) to nonmedical expenses, including administration and marketing expenses, and about 4 percent (\$30 PMPM) to the plans' profits. About 30 percent of beneficiaries were enrolled in plans that projected they would allocate less than 85 percent of their revenues to medical expenses.

As GAO concluded in its report, whether the value that MA beneficiaries receive in the form of reduced cost sharing, lower premiums, and additional benefits is worth the additional cost to Medicare is a decision for policymakers. However, if the policy objective is to subsidize health care costs of low-income Medicare beneficiaries, it may be more efficient to directly target subsidies to a defined low-income population than to subsidize premiums and cost sharing for all MA beneficiaries, including those who are well off. As Congress considers the design and cost of MA, it will be important for policymakers to balance the needs of beneficiaries and the necessity of addressing Medicare's long-term financial health.

Mr. Chairman and Members of the Subcommittee,

I am pleased to be here today to discuss the findings from our February 2006 report, *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs*.¹ Under the Medicare Advantage (MA) program, which represents an alternative to Medicare's traditional fee-for-service (FFS) program, beneficiaries may receive their covered benefits through private health plans that contract with Medicare. As of August 2007, approximately 20 percent of beneficiaries—or about 8.1 million beneficiaries—were enrolled in private plans, up from about 11 percent in 2003. The growth in enrollment was largely due to provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MDMA).² The MMA, among other things, increased payment rates for private plans to encourage their participation and enable plans to enhance their benefit packages to attract beneficiaries. The subsequent rapid growth of Medicare spending on the MA program, resulting from increases in both payment rates and enrollment, underscores the importance of today's hearing and the need to better understand how MA plans use the funding they receive.

In 2006, Medicare paid \$59 billion to MA plans—an estimated \$7.1 billion more than Medicare would have spent if MA plan beneficiaries had instead received care through the FFS program. Although adding a private health plan component to Medicare was envisioned in the 1980s as a potential source of program savings, private health plans have generally increased overall Medicare spending. Spending pressures increased as policy objectives evolved to foster private health plan participation and provide Medicare beneficiaries with more health plan choices. According to Medicare's Office of the Actuary, the additional spending for the MA program has hastened the exhaustion of the Federal Hospital Insurance Trust Fund that helps finance Medicare. It has also resulted in higher Medicare premiums for all beneficiaries—including those in the FFS program—because premiums paid by Medicare FFS beneficiaries are tied to the costs of both Medicare FFS and MA programs. The Congressional Budget Office estimated that \$54 billion in projected Medicare spending

¹Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs, GAO-06-322 (Washington, D.C.: February 2006).

²Pub. L. No. 308-173, § 201, et. seq., 117 Stat. 2806, 2176.

from 2009 through 2012 is the result of setting MA plan payments above Medicare FFS spending.³ The continued cost escalation associated with MA plans relative to Medicare FFS raise further concerns about the long-term financial implications of the MA program on the financial health of the Medicare program. Even without the added costs of the MA program, Medicare faces serious long-term financial challenges due to factors such as the rising cost of care and the retirement of the baby boom generation.

The federal government spends relatively more for beneficiaries in MA plans, in part, because most MA plans receive payments known as rebates, in addition to the payments they receive for providing Medicare-covered services. Beginning in 2006, MA plans were required to submit bids for providing Medicare-covered services. An MA plan qualifies for a rebate if its bid is less than a predetermined amount known as a benchmark.⁴ A portion, 75 percent, of the difference between the benchmark and the plan's bid, is returned to the plan in the form of a rebate.⁵ In 2007, the total amount of rebates paid to MA plans was about \$8.3 billion.⁶ Plans must use rebates to provide benefits or reduce beneficiary out-of-pocket costs in any combination of the following ways: (1) provide additional benefits not covered under Medicare FFS, such as dental and hearing benefits; (2) reduce beneficiary cost sharing; or (3) reduce premiums.

Proponents of the MA program note that rebates enable plans to provide valuable extra benefits to beneficiaries and reduce beneficiary out-of-pocket costs, thereby making health care more affordable. They point out that individuals with low incomes who do not qualify for other government health care coverage may receive some financial relief by enrolling in an MA plan. Critics question the cost of the current MA program and suggest that if the policy objective is to subsidize the health care costs of individuals with low incomes, it would be more efficient to directly target subsidies to a well-defined low-income population instead of subsidizing the cost of all MA beneficiaries. Further, they are concerned that the

³Congressional Budget Office, *The Medicare Advantage Program: Evolving Trends and Budgetary Effects* (Washington, D.C.: April 2007).

⁴Benchmarks represent the maximum amount that Medicare will pay plans, on a per beneficiary per month basis, for providing Medicare-covered services. Benchmarks always equal or exceed average per capita FFS spending.

⁵If a plan's bid for providing Medicare-covered services is higher than the benchmark, the plan must charge beneficiaries the difference in the form of a premium.

⁶Office of the Actuary, Centers for Medicare & Medicaid Services.

additional payments to MA plans are funded in part by the approximately 80 percent of beneficiaries in the FFS program who do not receive enhanced benefits.

My remarks today are based on the findings of our recent report.⁷ Specifically, my testimony will focus on (1) how plans projected they would allocate their rebates to additional benefits, reduced cost sharing, and reduced premiums; (2) how projected cost sharing in MA plans compared to projected cost sharing in Medicare FFS; and (3) how MA plans projected they would allocate their revenue to medical and other expenses.

To conduct our work for the report, we analyzed MA plans' 2007 projected revenues, projected costs, and covered benefits from data that plans submitted to the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare. We were limited to analyzing projections because MA plans are not required to submit detailed information on actual revenues or costs. We excluded plans that restricted enrollment and plans with service areas that are exclusively outside the 50 states and the District of Columbia.⁸ After all exclusions, we had 2,055 plans in our study that accounted for 71 percent of all MA beneficiaries. Our results are weighted by August 2007 plan enrollment and are standardized to represent a Medicare beneficiary of average health status. Our work for the report was conducted from April 2007 through February 2008 in accordance with generally accepted government auditing standards.

In summary, we found that most of the MA plans we reviewed received rebates and allocated them primarily to beneficiary cost sharing and premium reductions. In 2007, 91 percent of these MA plans (1,874 of 2,055) received an average rebate of about \$87 per member per month (PMPM). Based on the projections submitted to CMS, MA plans allocated about 80 percent of their rebates to beneficiary cost sharing and premium reductions. Plans allocated about 11 percent of the rebates to provide additional benefits, such as dental services, that are not covered under Medicare FFS. The average dollar amounts plans projected they would pay for additional benefits ranged from \$0.11 PMPM for international

⁷GAO-08-358.

⁸We excluded plans that have restrictions on enrollment, such as employer plans and plans that only cover certain Medicare FFS services.

outpatient emergency services to \$4 PMPM for dental care. Some plans charged an additional premium that supplements the rebate to pay for additional benefits, cost-sharing reductions, or a combination of the two. We also found that, despite the rebates paid to MA plans, some beneficiaries in MA plans could pay more for services than they would in FFS. For example, depending on the MA plan in which they were enrolled and their health care needs, some beneficiaries who frequently used home health or inpatient services could have had overall cost sharing that was higher than what they would have paid under Medicare FFS. Finally, we found that MA plans projected spending, on average, 87 percent of total revenues (\$663 of \$763 PMPM) on medical expenses. They projected that the remainder would be allocated to a combination of nonmedical expenses (9 percent), such as administration and marketing expenses, and plans' profits (4 percent).¹⁷ However, the percentage allocated to medical expenses varied widely by plan. About 39 percent of MA beneficiaries were enrolled in plans that projected spending less than 85 percent on medical expenses.

Background

Medicare FFS consists of Part A, hospital insurance, which covers inpatient stays, care in skilled nursing facilities, hospice care, and some home health care; and Part B, which covers certain physician visits, outpatient hospital treatments, and laboratory services, among other services. Most persons aged 65 and older, certain individuals with disabilities, and most individuals with end-stage renal disease are eligible to receive coverage for Part A services at no premium. Individuals eligible for Part A can also enroll in Part B, although they are charged a Part B premium.¹⁸ MA plans are required to provide benefits that are covered under the Medicare FFS program.¹⁹ Most Medicare beneficiaries who are eligible for Medicare FFS can choose to enroll in the MA program, operated through Medicare Part C, instead of Medicare FFS.²⁰ All Medicare

¹⁷In this testimony, we use the term profits to refer to for-profit and nonprofit plans' remaining revenue after medical and nonmedical expenses are paid.

¹⁸For 2007, the monthly Part B premium was set at \$83.58, although high-income beneficiaries pay more.

¹⁹MA plans do not cover hospice care, a benefit which is provided under Medicare FFS.

²⁰Individuals with end-stage renal disease are not eligible for most MA plans, unless they develop the disease while enrolled in an MA plan. 42 U.S.C. § 1395w-21(a)(3)(H)(2006).

beneficiaries, regardless of their source of coverage, can choose to receive outpatient prescription drug coverage through Medicare Part D.

Beneficiaries in both Medicare FFS and MA face cost-sharing requirements for medical services. In Medicare FFS, cost sharing includes a Part A and a Part B deductible, the amount beneficiaries must pay for services before Medicare FFS begins to pay.¹³ Medicare FFS cost sharing also includes coinsurance—a percentage payment for a given service that a beneficiary must pay,¹⁴ and copayments—a standard amount a beneficiary must pay for a medical service.¹⁵ Medicare allows MA plans to have cost-sharing requirements that are different from Medicare FFS's cost-sharing requirements, although an MA plan cannot require overall projected average cost sharing that exceeds what beneficiaries would be expected to pay under Medicare FFS. MA plans are permitted to establish dollar limits on the amount a beneficiary spends on cost sharing in a year of coverage, although Medicare FFS has no total cost-sharing limit.¹⁶ MA plans can use both out-of-pocket maximums, limits that can apply to all services but can exclude certain service categories, and service-specific maximums, which are limits that apply to a single service category. These limits help provide financial protection to beneficiaries who might otherwise have high cost-sharing expenses.

MA Plans Projected They Would Allocate Most of the Rebates to Beneficiaries in the Form of Reduced Cost Sharing and Reduced Premiums

MA plans projected that, on average, they would allocate most of the rebates to beneficiaries as reduced cost sharing and reduced premiums for Part B services, Part D services, or both. In 2007, almost all MA plans in our study (1,874 of the 2,055 plans, or 91 percent) received a rebate payment from Medicare that averaged \$87 PMPM. MA plans projected they would allocate 69 percent of the rebate (\$61 PMPM) to reduced cost sharing and 20 percent (\$17 PMPM) to reduced premiums. MA plans projected they would allocate relatively little of the rebates (11 percent or

¹³For example, in 2007, Medicare FFS required a deductible payment of \$962 before it began paying for an inpatient stay, and \$133 before it began paying for any Part B services.

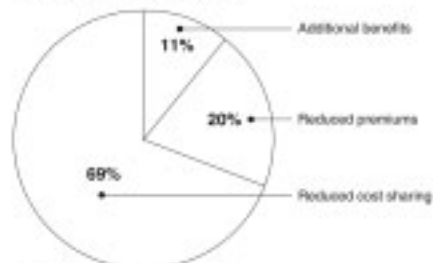
¹⁴For example, coinsurance might require a beneficiary to pay 20 percent of the total payment for physician visits.

¹⁵For example, in 2007, the Medicare copayment for days 61 through 90 of an inpatient stay was \$249 per day.

¹⁶Many Medicare FFS beneficiaries pay premiums for a type of supplemental insurance known as Medigap, which limits beneficiary cost sharing for Medicare-covered services. Medigap policies are not available to lower the cost sharing of MA beneficiaries.

\$10 PMPM) to additional benefits that are not covered under Medicare FFS. (See fig. 1.) On average, for plans that provided detailed cost estimates, the projected dollar amounts of the common additional benefits ranged from a low of \$0.11 PMPM for international outpatient emergency services to \$4 PMPM for dental services. Additional benefits commonly offered included dental services, health education services, and hearing services.

Figure 1: Projected Rebate Allocation to Additional Benefits, Premium Reductions, and Cost-Sharing Reductions, 2007



(Source: GAO analysis of 2007 OIG data for the 2007 test year.)

Note: Percentages are weighted by August 2007 plan enrollment. This analysis is based on 1,874 plans. We excluded from our analysis plans that restricted enrollment, plans with service areas that are exclusively outside the 50 states and the District of Columbia, and plans that did not receive a rebate.

About 41 percent of beneficiaries, or 2.3 million people, were enrolled in an MA plan that also charged additional premiums to pay for additional benefits, reduced cost sharing, or a combination of the two. The average additional premium charged was \$68 PMPM. Based on plans' projections, we estimated that about 77 percent of the additional benefits and reduction in beneficiary cost sharing was funded by rebates, with the remainder being funded by additional beneficiary premiums.

MA Plans Projected that MA Beneficiaries, on Average, Would Have Lower Cost Sharing than if They Were in Medicare FFS, but Some MA Beneficiaries Could Pay More

For 2007, MA plans projected that MA beneficiary cost sharing, funded by both rebates and additional premiums, would be 42 percent of estimated cost sharing in Medicare FFS. Plans projected that their beneficiaries, on average, would pay \$49 PMPM in cost sharing, and they estimated that the Medicare FFS equivalent cost sharing for their beneficiaries was \$116 PMPM.

Although plans projected that beneficiaries' overall cost sharing was lower, on average, than Medicare FFS cost-sharing estimates, some MA plans projected that cost sharing for certain categories of services was higher than Medicare FFS cost-sharing estimates. This is because overall cost sharing in MA plans is required to be actuarially equivalent or lower compared to overall cost sharing in Medicare FFS, but may be higher or lower for specific categories of services. For example, 19 percent of MA beneficiaries were enrolled in plans that projected higher cost sharing for home health services, on average, than in Medicare FFS, which does not require any cost sharing for home health services. Similarly, 16 percent of MA beneficiaries were in plans with higher projected cost sharing for inpatient services relative to Medicare FFS.⁷ (See table 1.) Some MA beneficiaries who frequently used these services with higher cost sharing than Medicare FFS could have had overall cost sharing that was higher than what they would pay under Medicare FFS.

⁷ Average cost sharing reflects expenditures for the entire population and includes both beneficiaries who are projected to use a certain category of service and beneficiaries who are not projected to use that service.

Table 1: Beneficiaries in MA Plans with Higher Projected Cost Sharing than Medicare FFS for a Given Service Category, 2007

	All plans Plans = 2,665 Beneficiaries = 5,784,368	
	Number	Percent
Home health services ¹	1,069,023	19
Inpatient services ²	807,246	15
Skilled nursing facility services	499,071	9
Durable medical equipment, prosthetics, and supplies	215,541	4
Part B drugs ³	101,418	2
Professional services ⁴	47,033	1
Outpatient facility services ⁵	31,497	1

Source: GAO analysis of 2007 CMS RA Pricing Tool data.

Note: We excluded plans that restricted enrollment and plans with service areas that are exclusively outside the 50 states and the District of Columbia.

¹Home health services include skilled nursing services, home health aides, and certain therapy services, all provided in the home setting.

²Many MA plans include cost sharing for professional services, such as physician visits received during an inpatient stay, in their inpatient cost-sharing amount. As a result, the cost sharing for professional services may be understated, while the inpatient cost sharing may be overstated. Professional services include physician visits, therapy, and radiology, among other services.

³Part B drugs are drugs that are covered under Medicare Part B, and they include drugs that are typically administered by a physician. Many plans excluded Part B drugs from the out-of-pocket maximum if they were obtained from a pharmacy, but according to CMS, did not exclude Part B drugs administered by a physician.

⁴Outpatient facility services include surgery, emergency, and other services provided in an outpatient facility.

Cost sharing for particular categories of services varied substantially among MA plans. For example, with regards to inpatient cost sharing, more than half a million beneficiaries were in MA plans that had no cost sharing at all. In contrast, a similar number of beneficiaries were in MA plans that required cost sharing that could result in \$2,000 or more for a 10-day hospital stay and \$3,000 or more for three average-length hospital stays.⁶ In Medicare FFS in 2007, beneficiaries paid a \$800 deductible for the first hospital stay in a benefit period, no deductible for subsequent

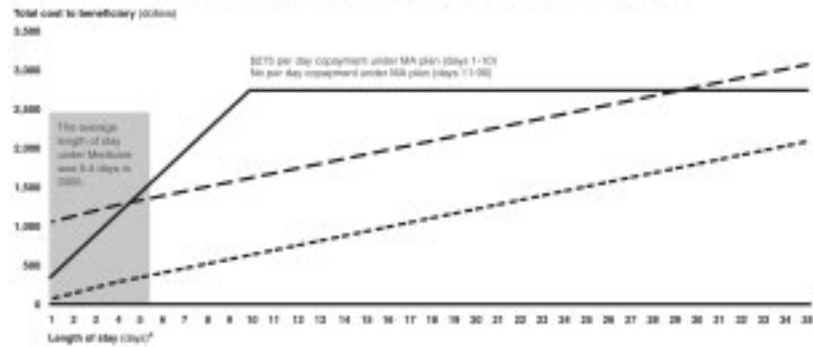
⁶The average length of stay for Medicare FFS was 5.4 days in 2005 according to a MedPAC analysis of Medicare cost report data.

hospital stays in the same benefit period, and a 30 percent coinsurance for physician services that averaged \$73 per day for the first 4 days of a hospital stay and \$58 per day for subsequent days in the stay.¹⁹

Figure 2 provides an illustrative example of an MA plan that could have exposed a beneficiary to higher inpatient costs than under Medicare FFS. While the plan in this illustrative example had lower cost sharing than Medicare FFS for initial hospital stays of 4 days or less as well as initial hospital stays of 30 days or more, for stays of other lengths the MA plan could have cost beneficiaries more than \$1,000 above out-of-pocket costs under Medicare FFS. The disparity between out-of-pocket costs under the MA plan and costs under Medicare FFS was largest when comparing additional hospital visits in the same benefit period, since Medicare FFS does not charge a deductible if an admission occurs within 60 days of a previous admission.

¹⁹Medicare FFS cost-sharing requirements also include a \$248 daily charge for hospital stays lasting between 61 and 90 days.

Figure 2: Example of an MA Plan with Inpatient Cost Sharing Different from the Medicare FFS Program



- MA plan cost sharing consisting of a copayment for days 1-10 of a hospital stay
- Medicare FFS estimated cost sharing for an initial hospital stay consisting of coinsurance for physician services received in the hospital and a deductible
- Medicare FFS estimated cost sharing for a subsequent hospital stay consisting of coinsurance for physician services received in the hospital (no deductible)

Source: CBO analysis of 2007 CMS Plan Benefit Package data and CMS actuarial data

Notes: In this example, the MA plan charged a \$275 daily copayment for the first 10 days of the hospital stay, and charged no additional copayment for days 11 through 90. The plan had a \$4,000 out-of-pocket maximum. In contrast, in 2007 Medicare FFS charged a \$662 deductible for an initial hospital stay of a benefit period and \$240 per day for days 91 through 90 of a hospital stay. Medicare FFS beneficiaries paid no deductible for an additional hospital stay if it occurred within 60 days of the previous stay. In addition, Medicare FFS beneficiaries must pay coinsurance for physician services received while in the hospital. The charges associated with these physician services averaged \$73 per day for the first 4 days of the hospital stay, and \$50 per day for the remaining days of a hospital stay through 90 days. This example assumes that the beneficiary was charged the average coinsurance. The actual amount of coinsurance a beneficiary pays varies based on the amount of services a beneficiary receives, and charges can be above or below the average.

^aNearly 98 percent of hospital stays under Medicare were 10 days or less in 2006 according to CBO data. About 1 percent of hospital stays were longer than 30 days.

Some MA plans had out-of-pocket maximums, which help protect beneficiaries against high spending on cost sharing. As of August 2007, about 48 percent of beneficiaries were enrolled in plans that had an out-of-pocket maximum. However, some plans excluded certain services from the out-of-pocket maximum. Services that were typically excluded were

Part B drugs obtained from a pharmacy,²⁰ outpatient substance abuse and mental health services, home health services, and durable medical equipment.

MA Plans Projected Approximately 87 Percent of Total Revenue Would be Spent on Medical Expenses

For 2007, MA plans projected that of their total revenues (\$783 PMPM), they would spend approximately 87 percent (\$683 PMPM) on medical expenses. Plans further projected they would spend approximately 9 percent of total revenue (\$71 PMPM) on nonmedical expenses, such as administration expenses and marketing expenses, and approximately 4 percent (\$30 PMPM) on the plans' profits, on average. There was variation among individual plans in the percent of revenues projected to be spent on medical expenses. For example, about 30 percent of beneficiaries—1.7 million—were enrolled in plans that projected spending less than 85 percent on medical expenses. While there is no definitive standard for the percentage of revenues that should be spent on medical expenses, Congress adopted the 85 percent threshold to require minimum thresholds for MA plans in the Children's Health and Medicare Protection Act of 2007.²¹

MA plans projected expenses separately for certain categories of nonmedical expenses, including marketing and sales. One type of MA plan—Private Fee-for-Service (PFFS)—allocated a larger percentage of revenue to marketing and sales than other plan types.²² On average, as a percentage of total revenue, marketing and sales expenses were 3.6 percent for PFFS plans compared to 2.4 percent for all MA plans.

²⁰According to CMS, plans that excluded Part B drugs from the out-of-pocket maximum excluded drugs obtained from a pharmacy and did not exclude drugs that were administered by a physician.

²¹The Children's Health and Medicare Protection Act of 2007 (CHAMP Act), H.R. 3162, 110th Cong., § 414 (2007), was passed in the House of Representatives on August 1, 2007.

²²PFFS plans allow beneficiaries to see any provider that accepts the plan's payment terms. Other plan types in addition to PFFS plans that we included in our analysis were Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Provider-Sponsored Organizations (PSOs). Beneficiaries in HMOs are generally restricted to seeing providers within a network, while beneficiaries in PPOs can see both in-network and out-of-network providers but must pay higher cost-sharing amounts if they use out-of-network services. PSOs are MA plans that are operated by a provider or providers.

Concluding Observations

Medicare spends more per beneficiary in MA than it does for beneficiaries in Medicare FFS, at an estimated additional cost to Medicare of \$54 billion from 2009 through 2012. In 2007, the average MA plan receives a Medicare rebate equal to approximately \$87 PMPM, on average. MA plans projected they would allocate the vast majority of their rebates—approximately 89 percent—to beneficiaries to reduce premiums and to lower their cost-sharing for Medicare-covered services. Plans projected they would use a relatively small portion of their rebates—approximately 11 percent—to provide additional benefits that are not covered under Medicare FFS. Although the rebates generally have helped to make health care more affordable for many beneficiaries enrolled in MA plans, some beneficiaries may face higher expenses than they would in Medicare FFS. Further, because premiums paid by beneficiaries in Medicare FFS are tied to both Medicare FFS and MA costs, beneficiaries covered under Medicare FFS are subsidizing the additional benefits and lower costs that MA beneficiaries receive. Whether the value that MA beneficiaries receive in the form of reduced cost sharing, lower premiums, and extra benefits is worth the increased cost borne by beneficiaries in Medicare FFS is a decision for policymakers. However, if the policy objective is to subsidize health-care costs of low-income Medicare beneficiaries, it may be more efficient to directly target subsidies to a defined low-income population than to subsidize premiums and cost sharing for all MA beneficiaries, including those who are well off. As Congress considers the design and cost of the MA program, it will be important for policymakers to balance the needs of beneficiaries—including those in MA plans and those in Medicare FFS—with the necessity of addressing Medicare's long-term financial health.

Mr. Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other Members of the Subcommittee may have at this time.

For further information about this testimony, please contact James Cosgrove at (302) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Christine Brudevold, Assistant Director; Jennie Apter, Alexander Dworkowitz, Gregory Gristo, Drew Long, and Christina C. Serra made key contributions to this statement.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "E-mail Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are \$2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, DC 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6001

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Ralph Dawn, Managing Director, dawnr@gao.gov, (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, younge1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

GAO

United States Government Accountability Office
Report to Congressional Requesters

February 2008

MEDICARE ADVANTAGE

Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs

This Report Is Temporarily Restricted Pending
Official Public Release.



GAO-08-319



Why GAO Did This Study

In 2006, the federal government spent about \$60 billion on Medicare Advantage (MA) plans, an alternative to the original Medicare fee-for-service (FFS) program. Although health plans were originally envisioned in the 1980s as a potential source of Medicare savings, such plans have generally increased program spending. Payments to MA plans have been estimated to be 12 percent greater than what Medicare would have spent in 2006 had MA beneficiaries been enrolled in Medicare FFS. Some policymakers are concerned about the cost of the MA program and its contribution to overall spending on the Medicare program, which already faces serious long-term financial challenges.

MA plans receive a per member per month (PMPM) payment to provide services covered under Medicare FFS. Almost all MA plans receive an additional Medicare payment, known as a rebate. Plans use rebates and sometimes additional beneficiary premiums to fund benefits not covered under Medicare FFS, reduce premiums, or reduce beneficiary cost sharing.

This report examines for 2007 (1) MA plans' projected rebate allocations; (2) additional benefits MA plans commonly covered and their costs; (3) MA plans' projected cost sharing; and (4) MA plans' allocation of projected revenues and expenses. GAO analyzed data on MA plans' projected revenues and covered benefits for the most common types of MA plans, accounting for 71 percent of all beneficiaries in MA plans.

To view the full product, including the scope and methodology, click on GAO-08-358. For more information, contact James Coagrove at (202) 512-7116 or coagrovej@gao.gov.

February 2008

MEDICARE ADVANTAGE

Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs

What GAO Found

In 2007, plans projected that relatively little of their rebates would be spent on additional benefits compared to cost-sharing and premium reductions. Of the average projected rebate amount of \$87 PMPM, plans projected they would allocate about \$10 PMPM (11 percent) to additional benefits, about \$61 PMPM (69 percent) to reduced cost sharing, and about \$17 PMPM (20 percent) to reduced premiums.

Using funding from both rebates and additional premiums, plans covered a variety of additional benefits not covered by Medicare FFS in 2007, including dental and vision benefits. On the basis of plans' projections, GAO estimated that rebates would pay for approximately 77 percent of additional benefits and additional beneficiary premiums would pay for the remaining 23 percent.

MA plans projected that, on average, beneficiaries in their plans would have lower cost sharing than Medicare FFS cost-sharing estimates, although some MA plans projected that their beneficiaries would have higher cost sharing for certain service categories, such as home health care and inpatient services. Because cost sharing was projected to be higher for some categories of services, beneficiaries who frequently used these services could have had overall cost sharing that would be higher than under Medicare FFS.

On average, MA plans projected that they would allocate about 87 percent of total revenue (\$683 of \$783 PMPM) to medical expenses, approximately 9 percent (\$71 PMPM) to non-medical expenses, including administration, marketing, and sales, and approximately 4 percent (\$30 PMPM) to the plans' margin, sometimes called the plans' profit. About 30 percent of beneficiaries were enrolled in plans that projected they would allocate less than 85 percent of their revenues to medical expenses.

Whether the value that MA beneficiaries receive in the form of reduced cost sharing, lower premiums, and additional benefits is worth the additional cost is a decision for policymakers. However, if the policy objective is to subsidize health care costs of low-income Medicare beneficiaries, it may be more efficient to directly target subsidies to a defined low-income population than to subsidize premiums and cost sharing for all MA beneficiaries, including those who are well off. As Congress considers the design and cost of MA, it will be important for policymakers to balance the needs of beneficiaries and the necessity of addressing Medicare's long-term financial health.

In commenting on a draft of this report, the Centers for Medicare & Medicaid Services expressed concern that the report was not balanced because it did not sufficiently focus on the advantages of MA plans. GAO disagrees. This report provides information on how plans projected they would use rebates and identified instances in which MA beneficiaries could have out-of-pocket costs higher than they would have experienced under Medicare FFS.

Contents

Letter		1
	Results in Brief	6
	Background	8
	MA Plans Projected That They Would Allocate Relatively Little of Their Rebates to Additional Benefits and the Majority to Reduced Cost Sharing	11
	MA Plans Used Rebates and Additional Premiums to Cover Additional Benefits Such as Dental, Hearing, and Vision	15
	MA Plans Projected That MA Beneficiaries, on Average, Would Have Lower Cost Sharing Than if They Were in Medicare FFS, but Some MA Beneficiaries Could Pay More	18
	Approximately 87 Percent of Total Revenue Projected to Be Allocated to Medical Expenses, but Projections Varied among Individual Plans	27
	Concluding Observations	30
	Agency and Other External Comments and Our Evaluation	31
Appendix I	Example of a Rebate Calculation	37
Appendix II	Scope and Methodology	39
Appendix III	Plan Variation in Rebate Amounts	44
Appendix IV	Plan Variation in the Out-of-Pocket Maximum	46
Appendix V	Comments from the Centers for Medicare & Medicaid Services	47
Appendix VI	GAO Contact and Staff Acknowledgments	50

Tables

Table 1: Rebate Amount PMPM Allocated to Additional Benefits, Premium Reductions, and Cost-Sharing Reductions by Plan Type, 2007	13
Table 2: Percentage of Beneficiaries in Plans That Charge an Additional Premium and Average Amount of Additional Premium by Plan Type, 2007	14
Table 3: Average Projected PMPM Costs of Additional Benefits by Service Category and Plan Type for Plans That Offered Benefits and Reported Costs, 2007	17
Table 4: Beneficiaries in MA Plans with Higher Projected Cost Sharing Than Medicare FFS for a Given Service Category by Plan Type, 2007	20
Table 5: MA Plans That Exclude Some Services under a Service Category from Their Out-of-Pocket Maximum	26
Table 6: The Calculation of the Rebate for Two Hypothetical MA Plans	37
Table 7: Rebate Amount Allocated to Additional Benefits, Premium Reductions, and Cost-Sharing Reductions by Plan Type, 2007	44
Table 8: Variation in Values of Out-of-Pocket Maximum by Plan Type, 2007	46

Figures

Figure 1: Projected Rebate Allocation to Additional Benefits, Premium Reductions, and Cost-Sharing Reductions by Plan Type, 2007	12
Figure 2: Percentage of Beneficiaries in Plans Covering Additional Benefits by Plan Type, 2007	16
Figure 3: Average Projected Cost Sharing for MA Beneficiaries Compared to Their Cost Sharing in Medicare FFS, by Plan Type, 2007	19
Figure 4: Example of an MA Plan with Inpatient Cost Sharing Different from the Medicare FFS Program	23
Figure 5: Beneficiaries in MA Plans by Out-of-Pocket Maximum Amount and Plan Type, 2007	25
Figure 6: Percentage of Beneficiaries in MA Plans That Project Allocating Less Than 85 Percent of Total Revenues to Medical Expenses, by Plan Type, 2007	28

Figure 7: MA Plans' Projected Marketing and Sales Expenses by Plan Type, 2007

30

Abbreviations

AHIP	America's Health Insurance Plans
CHAMP Act	Children's Health and Medicare Protection Act of 2007
CMS	Centers for Medicare & Medicaid Services
FFS	fee-for-service
HMO	Health Maintenance Organization
MA	Medicare Advantage
MedPAC	Medicare Payment Advisory Commission
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSA	Medical Savings Account
PFFS	Private Fee-for-Service
PMFPM	per member per month
PPO	Preferred Provider Organization
PSO	Provider-Sponsored Organization
SNP	Special Needs Plan

This is a work of the U.S. government and is not subject to copyright protection in the United States. It may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



United States Government Accountability Office
Washington, DC 20548

February 22, 2008

Congressional Requesters

In 2006, the federal government spent an estimated \$39 billion on the Medicare Advantage (MA) program, an alternative to the original Medicare fee-for-service (FFS) program.¹ The MA program provides health care coverage to Medicare beneficiaries through private health plans, referred to as MA plans. As of August 2007, 8.1 million people—about one out of every five Medicare beneficiaries—were enrolled in an MA plan. Although private health plans were originally envisioned in the 1980s as a potential source of Medicare savings, such plans have generally increased overall program spending. Medicare spending on private health plans has increased rapidly since the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA),² rising 64 percent from 2004 to 2006, while enrollment has increased by more than 50 percent. The MMA increased payment rates for private health plans and allowed for larger annual rate increases, among other things.³ These payment increases enabled MA plans to spend more money on additional benefits relative to those available under Medicare FFS, such as vision and hearing coverage; reductions in cost sharing—the amount a beneficiary pays for covered services; and reductions in the premiums that many Medicare FFS beneficiaries pay for coverage of outpatient services and outpatient drugs. Beginning in 2006, MA plans were required to submit bids for providing Medicare-covered services. MA plans that submitted bids below predetermined benchmarks received additional payments, known as rebates, and were required to spend their rebates on additional

¹Medicare is the federally financed health insurance program for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional insurance, and covers hospital outpatient, physician, and other services. Medicare Parts A and B are known as original Medicare or Medicare FFS. Medicare beneficiaries have the option of obtaining coverage for Medicare Part A and B services from private health plans that participate in Medicare's MA program—also known as Medicare Part C. All Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Medicare Part D.

²Pub. L. No. 108-173, § 201, et. seq., 117 Stat. 2003, 2176.

³Private health plans had previously provided health coverage to Medicare beneficiaries through the Medicare + Choice program. MMA retained the program "Medicare Advantage" and changed certain payments and other aspects of the program.

benefits, reduced cost sharing, reduced premiums, or a combination of the three.

As the MA program has grown, some policymakers and congressional advisors have raised concerns about the design and cost of the program as well as its effect on overall Medicare spending. The Medicare Payment Advisory Commission (MedPAC) found that payments to MA plans in 2000 exceeded by 12 percent what Medicare would have paid had MA beneficiaries received services through Medicare FFS.⁴ The Congressional Budget Office estimated that \$54 billion in projected Medicare spending from 2009 through 2012 is the result of setting MA plan payments above Medicare FFS spending.⁵ MA plans' payments thus place an additional financial burden on the Medicare program, which the Comptroller General and others have noted already faces serious long-term financial challenges resulting from rising health care costs and the retirement of the baby boom generation.⁶ Proponents of the MA program assert that the current level of MA plan payments has allowed plans to offer valuable additional benefits and make health care services more affordable for beneficiaries, particularly in rural areas where private plan options had been very limited. Further, they note that the MA program provides beneficiaries with private plan choices and enables them to select plans that reflect their preferences for premiums and cost sharing. They also point out that individuals with low incomes who do not qualify for other government health care coverage may receive some financial relief by enrolling in an MA plan. Critics of the current MA program suggest that if the policy objective is to subsidize the health care of individuals with low incomes, it would be more efficient to directly target subsidies to a well-defined low-income population instead of subsidizing the health care costs of all MA beneficiaries. Program critics also assert that a large portion of the additional payments to MA plans goes to profit and administrative costs and that some MA beneficiaries face higher cost sharing than they would if they received coverage through Medicare FFS. Questions have also been raised that while the MA program provides beneficiaries with many health

⁴Medicare Payment Advisory Commission, *The Medicare Advantage Programs and MedPAC Recommendations* (Washington, D.C.: April 2007).

⁵Congressional Budget Office, *The Medicare Advantage Program: Enrollment Trends and Budgetary Effects* (Washington, D.C.: April 2007).

⁶For a discussion of Medicare's long-term financial challenges, see GAO, *Long-Term Budget Outlook: Saving Our Future Requires Tough Choices Today*, GAO-07-0427 (Washington, D.C.: Jan. 11, 2007).

plan choices, it can be difficult for even a sophisticated buyer to understand the implications of different cost-sharing arrangements. In addition, some policymakers are concerned that because premiums paid by beneficiaries in Medicare FFS are tied to both Medicare FFS and MA program spending, the excess payments to MA plans result in higher premiums for all Medicare beneficiaries.

Medicare pays MA plans a per member per month (PMPM) amount that is based on a plan's bid—its projection of the revenue it requires to provide a beneficiary with services that are covered under Medicare FFS, and a benchmark—the maximum amount Medicare will pay the plan to serve an average beneficiary. Benchmarks vary by county, and in 2007, every county in the United States had a benchmark that was at least as high as average Medicare FFS spending PMPM in that county. If the plan's bid is higher than the benchmark, Medicare pays the plan the amount of the benchmark, and the plan must charge beneficiaries a premium to collect the amount by which the bid exceeds the benchmark.³ If the plan's bid is lower than the benchmark, Medicare pays the plan the amount of the bid and makes an additional rebate payment to the plan equal to 75 percent of the difference between the benchmark and the bid. Plans use the rebate to provide their beneficiaries with additional benefits beyond those offered in Medicare FFS, reduce premiums, reduce cost sharing, or any combination of the three. In 2007, the total amount of rebates paid to MA plans was about \$8.3 billion. (See app. I for more information about how rebates are calculated.) Regardless of whether a plan's bid is above or below the benchmark, a plan may charge its beneficiaries an additional premium to provide additional benefits or reductions in cost sharing that are not otherwise financed by rebates.⁴

Given the additional spending—including rebates—for the MA program, you asked that we undertake a study on MA plans' rebates, benefit packages, and revenues. This report examines for 2007 (1) how MA plans projected they would allocate the rebates they receive, (2) what additional benefits MA plans commonly covered with the rebates and additional

³Medicare compares a plan's bid to the benchmark after adjusting the benchmark to reflect the health status of the plan's enrollees.

⁴About 85 percent of MA beneficiaries are in plans that receive rebates and 41 percent of MA beneficiaries are in plans that charge additional premiums. Some plans also offer optional benefits, which beneficiaries can purchase with the standard benefit package. Rebates can not be used for optional benefits.

premiums and the projected costs of these additional benefits, (3) how MA plans' projected beneficiary cost sharing overall and by type of service compared to Medicare FFS, and (4) how MA plans projected they would allocate their revenue to medical and other expenses.

We used two primary data sources in our analyses, the 2007 Bid Pricing Tool data and the 2007 Plan Benefit Package data that MA plans submitted to the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare. The bid pricing data contain MA plans' projections of their revenue requirements and revenue sources. Specifically, the bid pricing data contain information on the amount of rebates and additional premiums plans project they will require to fund additional benefits, reduced premiums, and reduced cost sharing. The bid pricing data also contain information about how plans' projected cost sharing compared to estimates of cost sharing in Medicare FFS and plans' projections of revenue requirements—depending on medical expenses, spending on non-medical expenses (such as marketing, sales, and administration) and their margins.⁷ The benefit package data contain detailed information on the benefits and cost-sharing arrangements of plans.

We analyzed bid pricing data and benefit package data from four different plan types, which together account for 68 percent of MA enrollment—including Health Maintenance Organizations (HMO), Private Fee-for-Service (PFFS) Plans, Preferred Provider Organizations (PPO), and Provider-Sponsored Organizations (PSO).⁸ Because there were only 22 PSOs and enrollment in those plans was only 1 percent of total MA enrollment, we did not report results separately for PSOs, but included them in the aggregated results we reported for all MA plans. We excluded plans that have restrictions on enrollment—such as employer plans and Special Needs Plans (SNP)—and bids for plans that only cover certain

⁷Margins, sometimes referred to as profits, refer to plans' remaining revenue after medical and non-medical expenses are paid. In certain circumstances, such as for new market entrants, CMS allows a plan to have a negative margin, meaning that the plan's revenue is less than its combined medical and non-medical expenses.

⁸HMOs account for 31 percent of total MA enrollment; PFFS plans 21 percent; PPOs 5 percent; and PSOs 1 percent, totaling to 58 percent of enrollment. The remaining 2 percent of beneficiaries were enrolled in Medical Savings Accounts and regional PPOs. Beneficiaries in HMOs are generally restricted to seeing providers within a network, while PFFS beneficiaries can see any provider that accepts the plan's payment terms. Beneficiaries in PPOs can see both in-network and out-of-network providers but must pay higher cost-sharing amounts if they use out-of-network services. PSOs are MA plans that are operated by a provider or providers.

Medicare FFS services.¹¹ We also excluded plans with service areas that are exclusively outside the 50 states and the District of Columbia. After all exclusions, we had 2,055 plans in our study that accounted for 71 percent of all beneficiaries in MA plans. Unless otherwise noted, the analyses were based on these 2,055 plans and their beneficiaries. To address our study questions, we did the following:

- To determine how plans projected they would allocate the rebates they receive, we used the bid pricing data. We applied the proportion of the combined rebate and additional premium allocated to additional benefits, reduced premiums, and reduced cost sharing to the projected total. We restricted this analysis to those plans that received a rebate—1,874 of the 2,055 plans.
- To identify the additional benefits MA plans commonly covered with rebates and additional premiums, and the projected costs of these additional benefits, we analyzed both the benefit package and bid pricing data. We used the benefit package data to identify the additional benefits plans covered and used the bid pricing data to identify the projected cost of these additional benefits. When we analyzed the projected cost of additional benefits, we included both the rebate payments and additional premiums. We included rebates and additional premiums, rather than solely considering the effects of rebates, because rebates and premiums together fund the additional benefits that MA beneficiaries will receive. If we had estimated the cost of additional benefits funded only by the rebates, that amount would have been lower than the amount we report.
- To compare projected beneficiary cost sharing in the MA and Medicare FFS programs, we used both the bid pricing and the benefit package data. We used the bid pricing data to quantify the projected cost-sharing reduction, using the plans' projections of the average cost-sharing expenditure on a PMPM basis, and compared this to CMS estimates of what the average PMPM cost-sharing expenditure would be in Medicare FFS. To obtain details on the specific cost-sharing arrangements used by the plans, we used the benefit package data. As was the case for our analysis of additional benefits, the amounts we reported for average PMPM cost sharing and cost-sharing reductions were based on the amounts projected by the plans and included funding from both rebates and additional premiums. If we had estimated the amount of cost sharing funded only by the rebates, the PMPM cost-sharing amounts would have

¹¹Some MA plans only cover Medicare Part B services.

been higher and the cost-sharing reduction amounts would have been lower.

- To identify how plans projected they would allocate their revenue to medical and other expenses, we used the bid pricing data.

Throughout the report, dollar amounts are adjusted to reflect a beneficiary of average health status. Where noted, we used August 2007 MA plan enrollment numbers to weight our results.

To determine the reliability of the bid pricing, benefits, and enrollment data, we spoke with CMS officials about the strengths and limitations of these data sets. We also conducted logic tests to ensure that the bid pricing data were reasonable and consistent, and compared the bid pricing and benefits data to ensure consistency, where applicable, across the data sets. In some cases, there were discrepancies between the two data sources. For example, some plans indicated that they had an additional benefit in the benefit package data, but did not price that additional benefit in the bid pricing data. CMS officials indicated that these discrepancies could be due, in part, to the different purposes of the benefit package and bid pricing data sets, and resulting different benefit categorizations. CMS officials said discrepancies may also be the result of some plans with low projected amounts for additional benefits categorizing those benefits as Medicare-covered services, or the bid pricing data may accurately reflect low projected prices that round to zero. In general, based on CMS's recommendations, we used the benefit package data as the most reliable data source for identifying specific benefits covered by plans, and used the bid pricing data to identify costs. We determined that the data used were sufficiently reliable for the purposes of this report. However, verifying that the projections presented in the bid pricing data actually reflect plan revenues and expenditures was beyond the scope of our work. See appendix II for more details on our scope and methodology. We conducted our work from April 2007 through February 2008 in accordance with generally accepted government auditing standards.

Results in Brief

In 2007, MA plans that received rebates projected that relatively little of the rebates would be spent on additional benefits compared to cost-sharing and premium reductions. Of the average projected rebate amount of \$87 PMPM, plans projected that they would allocate about \$10 PMPM (11 percent) to additional benefits, about \$61 PMPM (69 percent) to

reduced cost sharing, and about \$17 PMPM (20 percent) to reduced premiums.

Using funding from rebates, additional premiums, or both, plans covered a variety of additional benefits in 2007, including dental, hearing, and vision benefits. The average projected PMPM costs of specific additional benefits across all MA plans ranged from \$0.11 PMPM for international outpatient emergency services to \$4 PMPM for dental care. On the basis of plans' projections, we estimated that rebates would pay for approximately 77 percent of these additional benefits, and additional beneficiary premiums would pay for the remaining 23 percent.

MA plans projected that, on average, beneficiaries in their plans would pay less in cost sharing than what their cost sharing would be in the Medicare FFS program, although some MA plans projected that their beneficiaries would have higher cost sharing for certain service categories. For example, 19 percent of MA beneficiaries were in plans that projected higher cost sharing for home health services and 16 percent of beneficiaries were in plans that projected higher cost sharing for inpatient services. Because cost sharing was projected to be higher for some categories of services, beneficiaries who frequently used these services could have had overall cost sharing that would be higher than under Medicare FFS. Similar to payments for additional services, we estimated that rebates would pay for about 77 percent of the cost-sharing reduction and the remainder would be paid for with additional beneficiary premiums.

Plans' total revenues in 2007 were \$783 PMPM, on average, of which plans projected they would allocate approximately 87 percent (\$683 PMPM) to medical expenses—referred to as a medical loss ratio of 0.87. In addition, they projected that they would allocate approximately 9 percent of total revenue (\$71 PMPM) to non-medical expenses, and approximately 4 percent (\$30 PMPM) to the plans' margin—sometimes called a profit. About 30 percent of beneficiaries were enrolled in plans with a medical loss ratio of less than 0.85.

Medicare spends more per beneficiary in the MA program than it does for beneficiaries in Medicare FFS, at an estimated additional cost to Medicare of \$64 billion from 2009 through 2012. MA beneficiaries generally, but not always, receive additional value in the form of reduced cost sharing, lower premiums, and extra benefits, compared to Medicare FFS beneficiaries. Whether the additional value that MA beneficiaries receive is worth the additional cost to Medicare FFS beneficiaries and other taxpayers is a

decision for policymakers. If the policy objective is to subsidize health care costs of low-income Medicare beneficiaries, it may be more efficient to directly target subsidies to a defined low-income population than to subsidize premiums and cost sharing for all MA beneficiaries, including those who are well off. As Congress considers the design and cost of the MA program, it will be important for policymakers to balance the needs of MA beneficiaries and Medicare FFS beneficiaries with the necessity of addressing Medicare's long-term financial health.

In commenting on a draft of this report, CMS stated that we did not consider that the majority of MA benefit packages in 2007 were better than Medicare FFS and expressed concern that the report was not balanced because it did not sufficiently focus on the advantages of MA plans. They also noted that while they did not disagree with our finding that some beneficiaries in MA plans could have higher out-of-pocket costs, we did not recognize certain factors that would have mitigated the impact of the finding. We disagree with CMS. Specifically, we recognized in the report that, on average, plans projected MA beneficiary cost sharing that was 42 percent of estimated cost sharing in Medicare FFS. Our report provides an assessment of how MA plans projected they would use their rebates in 2007, and identified important issues related to cost sharing. America's Health Insurance Plans (AHIP) indicated that they agreed with our methodology, but raised certain points that they thought the report should have made or emphasized. We added these points to the report as appropriate.

Background

MA plans are required to cover benefits that are covered under the Medicare FFS program.¹² Medicare FFS consists of Part A, hospital insurance—which covers inpatient stays, care in skilled nursing facilities, hospice care, and some home health care, and Part B, which covers certain physician, outpatient hospital, and laboratory services, among other services. Persons aged 65 and older who meet Medicare's work requirement, certain individuals with disabilities, and most individuals with end-stage renal disease receive coverage for Part A services and pay no premium.¹³ Individuals eligible for Part A can also enroll in Part B,

¹²MA plans do not cover hospice care, a benefit that is provided under Medicare FFS.

¹³U.S. citizens and permanent residents meet Medicare's work requirement if they worked for at least 10 years in Medicare-covered employment or if their spouse worked for at least 10 years in Medicare-covered employment.

although they are charged a Part B premium.¹¹ For 2007, the monthly Part B premium was set at \$63.50, although high-income beneficiaries paid more. Most Medicare beneficiaries who are eligible for Medicare FFS can choose to enroll in the MA program instead of Medicare FFS.¹² MA plans operate under Medicare Part C.

All Medicare beneficiaries, regardless of their source of coverage, can choose to receive prescription drug coverage through Medicare Part D. Medicare FFS beneficiaries can enroll in stand-alone prescription drug plans, which are operated by private plan sponsors, and they generally must pay a premium to receive Part D coverage. MA beneficiaries who opt for prescription drug coverage generally receive that coverage through their MA plans, which may or may not charge an additional premium for Part D coverage. Beneficiaries enrolled in a PFFS plan that does not offer Part D coverage are allowed to enroll in a stand-alone prescription drug plan.

Beneficiaries in both Medicare FFS and MA face cost-sharing requirements for medical services. Cost sharing gives beneficiaries a financial incentive to be mindful of the costs associated with using services. Medicare FFS cost sharing takes different forms. It includes both a Part A and a Part B deductible, which is the amount a beneficiary pays for services before Medicare FFS begins to pay. For 2007, Medicare FFS required a deductible payment of \$882 before it began paying for an inpatient stay, and \$131 before it began paying for any Part B services. Cost sharing also includes coinsurance—a percentage payment for a given service that a beneficiary must pay, such as 20 percent of the total payment for physician visits, and copayments—a standard amount a beneficiary must pay for a medical service, such as \$248 per day for days 61 through 90 of an inpatient stay in 2007.

Medicare allows MA plans to have cost-sharing requirements that are different from Medicare FFS's cost-sharing requirements. Plans may require more or less cost sharing than Medicare FFS for a given service, although, on average, a plan cannot require overall cost sharing that exceeds what beneficiaries would be expected to pay under Medicare FFS.

¹¹Beneficiaries who are also eligible for Medicaid can have their Part B premium paid for by their state Medicaid program.

¹²Individuals with end-stage renal disease are not eligible for most MA plans, unless they develop the disease while enrolled in an MA plan. 42 U.S.C. § 1395w-22(a)(7)(B)(2006).

MA plans may establish dollar limits on the amount a beneficiary spends on cost sharing in a year of coverage. In contrast, Medicare FFS has no total cost-sharing limit.⁵⁴ Plans can use both out-of-pocket maximums, limits that can apply to all services but can exclude certain service categories, and service-specific maximums, limits that apply to one service category. These limits help provide financial protection to beneficiaries who might otherwise have high cost-sharing expenses.

CMS officials said that they evaluate the cost-sharing arrangements of MA plans to determine if cost sharing is too high for services likely to be used by a beneficiary with below average health status. According to CMS officials, in 2007, if an MA plan (1) had no out-of-pocket maximum, (2) had an out-of-pocket maximum above \$5,100, or (3) had an out-of-pocket maximum of \$5,100 or below and excluded certain categories of service from that maximum, CMS compared the plan's cost sharing for certain service categories to thresholds that CMS based on Medicare FFS cost-sharing levels.⁵⁵ If a plan exceeded one or more thresholds, CMS may have sought to negotiate with the plan over its cost sharing. According to CMS officials, the decision to negotiate was based on various factors, including the extent to which the thresholds were exceeded, local market comparisons, and the extent to which high cost sharing in one category was balanced with low cost sharing in another.⁵⁶

⁵⁴Many Medicare FFS beneficiaries pay premiums for a type of supplemental insurance known as Medigap, which limits beneficiary cost sharing for Medicare-covered services. Medigap policies do not cover the cost sharing of MA beneficiaries.

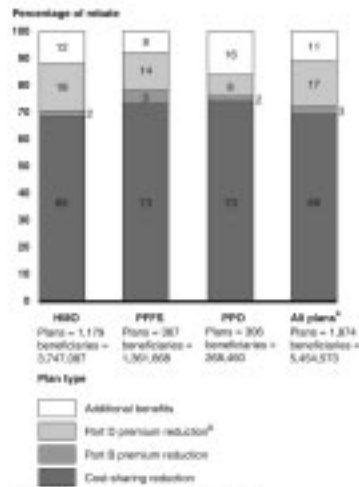
⁵⁵CMS officials said that the thresholds that trigger further review by CMS are at or above Medicare FFS cost-sharing levels. For example, in 2007 Medicare FFS beneficiaries were charged a \$692 deductible for hospital services, so the cost-sharing threshold was at or above \$692.

⁵⁶CMS officials indicated that in evaluating 2008 plans, they stratified plans based on having an out-of-pocket maximum of \$5,250, instead of \$5,100.

**MA Plans Projected
That They Would
Allocate Relatively
Little of Their Rebates
to Additional Benefits
and the Majority to
Reduced Cost Sharing**

MA plans that received rebates projected, on average, that their rebates would be \$87 PMPM. The plans projected that they would allocate a relatively small amount to additional benefits, compared to cost-sharing and premium reductions. Plans projected that, on average, about 11 percent of their rebates would be allocated to additional benefits, 69 percent to reduced cost sharing, 17 percent to Part D premium reductions, and 3 percent to Part B premium reductions. The average projected rebate allocation to additional benefits and reduced premiums varied by plan type. For example, PPOs projected that they would allocate less to Part D premium reductions and more to additional benefits than other plan types. PFFS plans projected that they would allocate less to additional benefits than other plan types. (See fig. 1.)

Figure 1: Projected Rebate Allocation to Additional Benefits, Premium Reductions, and Cost-Sharing Reductions by Plan Type, 2007



Source: GAO analysis of 2007 OASD for Pricing Test data.

Notes: Percentages may not sum to 100 due to rounding. Percentages are weighted by August 2007 plan enrollment. Employer plans, Part B only plans, SNPs, regional PPOs, and plans with service areas that are exclusively outside of the 50 states and the District of Columbia were excluded from the analysis. This analysis includes only the 1,874 plans that received a rebate.

^aThe "All plans" category includes HMOs, PFFS plans, PPOs, and PSDs. Results are not reported separately for PSDs because there were only 22 PSD plans and enrollment in these plans constituted 1 percent of total MA enrollment.

^bOf the 1,874 plans that received a rebate, 1,423 offered Part D benefits to their beneficiaries. Of those that offered Part D, 1,037 reduced Part D premiums.

In dollar terms, the average projected rebates varied by plan type, from \$55 PMPM for PPOs to \$63 PMPM for HMOs. The dollar portions of the rebates that plans allocated to cost sharing varied, reflecting the variation in the average amount of the rebate. For example, on average, both PFFS plans and PPOs projected that they would allocate 73 percent of their rebate to cost-sharing reductions, but PFFS plans projected this would

average \$51 PMPM while PPOs projected this would average \$41 PMPM.¹⁰ (See table 1.) For more information on the variation in how plans allocated rebates and the rebate amounts, see appendix III.

Table 1: Rebate Amount PMPM Allocated to Additional Benefits, Premium Reductions, and Cost-Sharing Reductions by Plan Type, 2007

	HMO Plans = 1,179 Beneficiaries = 3,747,067	PFFS Plans = 367 Beneficiaries = 1,261,668	PPO Plans = 305 Beneficiaries = 293,493	All plans ^a Plans = 1,874 Beneficiaries = 5,494,573
Rebate average	\$93.29	\$70.06	\$55.29	\$67.44
Amount of rebate allocated to				
Additional benefits ^b	11.36	5.58	9.08	9.95
Part D premium reduction ^c	16.38	9.51	4.51	14.70
Part B premium reduction	1.59	3.62	1.06	2.29
Cost-sharing reduction ^d	63.96	51.34	40.61	60.51

Source: GAO's analysis of 2007 GAO fee pricing data sets.

Notes: Values are weighted by August 2007 plan enrollment and are standardized to represent a beneficiary of average health status. Employer plans, Part B only plans, SMPs, regional PPOs, and plans with service areas that are exclusively outside of the 50 states and the District of Columbia are excluded from the analysis. This analysis included only the 1,874 plans that received a rebate.

^aThe "All plans" category includes HMOs, PFFS plans, PPOs, and PSOs. Results are not reported separately for PSOs because there were only 22 PSO plans and enrollment in those plans constituted 1 percent of total MA enrollment.

^bThe rebate amounts allocated to cost sharing and additional benefits included some non-medical expenses, such as administrative costs and plans' margins.

^cOf the 1,874 plans that received a rebate, 1,425 offered Part D benefits to their beneficiaries. Of those that offered Part D, 1,837 reduced Part D premiums.

While nearly all MA enrollees were in plans that received rebates, some plans charged additional premiums either in addition to the rebate or as the sole funding source to pay for additional benefits, reduced cost sharing, or a combination of the two. In 2007, approximately 41 percent of beneficiaries (about 2.3 million people) were enrolled in an MA plan that charged an additional premium. There were differences in the extent to which plans charged additional premiums by plan type. For example, 31 percent of beneficiaries enrolled in PFFS plans were charged an additional premium, compared to 83 percent of beneficiaries enrolled in

¹⁰The rebate amounts allocated to cost sharing include some non-medical expenses, such as administrative costs and plans' margins.

PPOs. Of plans that charged an additional premium, the average additional premium was \$58 PMPM.²⁶ (See table 2.) Plans that received rebates and charged additional premiums had lower rebates (\$54 PMPM on average), than plans that received rebates and did not charge an additional premium (\$107 PMPM on average), and these plans allocated less of their rebates to premium reductions and more to additional benefits and cost-sharing reductions.²⁷

Table 2: Percentage of Beneficiaries in Plans That Charge an Additional Premium and Average Amount of Additional Premium by Plan Type, 2007

	HMO Plans = 1,208 Beneficiaries = 3,977,161	PFFS Plans = 479 Beneficiaries = 1,466,103	PPO Plans = 345 Beneficiaries = 301,746	All plans ^a Plans = 2,055 Beneficiaries = 5,754,368
Percentage of beneficiaries in plans that charge an additional premium and do not receive a rebate	5	3	11	5
Percentage of beneficiaries in plans that charge an additional premium and receive a rebate	36	26	72	35
Average amount of additional premium (PMPM)	\$61.67	\$42.09	\$60.47	\$58.00

Source: OIG analysis of 2007 CMS MA Pricing Tool data.

Notes: Values are weighted by August 2007 plan enrollment and are standardized to represent a beneficiary of average health status. Employer plans, Part B only plans, SAPs, regional PPOs, and plans with service areas that are exclusively outside of the 50 states and the District of Columbia were excluded from the analysis.

^aThe "All plans" category includes HMOs, PFFS plans, PPOs, and PSOs. Results are not reported separately for PSOs because there were only 22 PSO plans and enrollment in these plans constituted 1 percent of total MA enrollment.

²⁶The average additional premium has been standardized to represent a beneficiary of average health status.

²⁷The 889 plans that received a rebate and did not charge an additional premium projected that they would allocate 11 percent (\$11 PMPM) of their rebate to additional benefits, 21 percent (\$22 PMPM) to Part D premium reductions, 3 percent (\$3 PMPM) to Part B premium reductions, and 65 percent (\$67 PMPM) to cost-sharing reductions. The 988 plans that charged additional premiums and received a rebate projected that they would allocate 14 percent (\$6 PMPM) of their rebate to additional benefits, 3 percent (\$3 PMPM) to Part D premium reductions, 3 percent (\$3 PMPM) to Part B premium reductions, and 80 percent (\$44 PMPM) to cost-sharing reductions. These numbers are enrollment weighted.

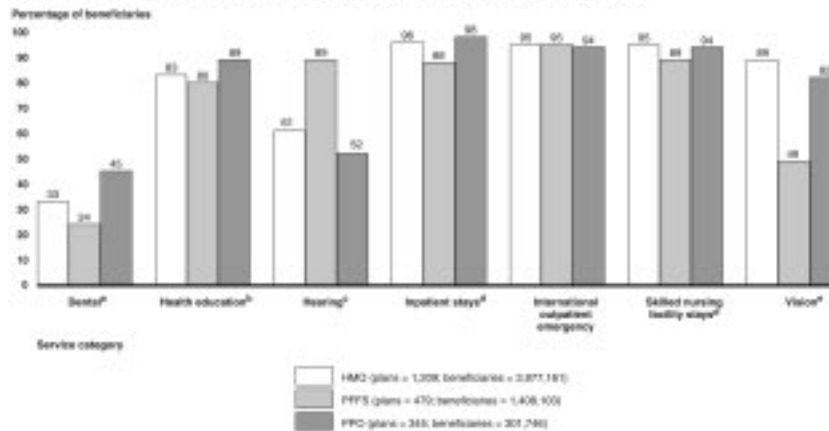
**MA Plans Used
Rebates and
Additional Premiums
to Cover Additional
Benefits Such as
Dental, Hearing, and
Vision**

MA plans covered several common additional benefits with the rebates, additional premiums, or both. These benefits included:

- dental benefits, which may include oral exams, tooth cleanings, fluoride treatments, dental X-rays, or emergency dental services;
- health education benefits, which may include nutritional training, smoking cessation, health club memberships, or nursing hotlines;
- hearing benefits, which may include coverage for hearing tests, hearing aid fittings, and hearing aid evaluations;
- inpatient facility stays, which may include additional inpatient facility days beyond those covered under Medicare FFS;
- international coverage for outpatient emergency services;
- skilled nursing facility stays, which include days in a skilled nursing facility beyond those covered under Medicare FFS; and
- vision benefits, which may include coverage for routine eye exams, contacts, or eyeglasses (lenses and frames).

Almost all plans covered international outpatient emergency services and additional days in a skilled nursing facility and inpatient facility beyond what Medicare FFS covers. The percentage of plans covering dental, vision, or hearing services varied by plan type. For example, PFFS plans were more likely to cover hearing and less likely to cover dental and vision services than HMOs and PPOs. (See fig. 2.)

Figure 2: Percentage of Beneficiaries in Plans Covering Additional Benefits by Plan Type, 2007



Source: GAO analysis of 2007 CMS data from two sets.

Notes: The percentages of beneficiaries in plans that have additional benefits are as of August 2007. This analysis included additional benefits funded by both rebates and additional premiums. Employer plans, Part B only plans, SNPs, regional PPOs, and plans with service areas that are exclusively outside of the 50 states and the District of Columbia were excluded from the analysis.

^aDental benefits may include oral exams, teeth cleanings, fluoride treatments, dental X-rays, or emergency dental services.

^bHealth education benefits may include nutritional training, smoking cessation, health club memberships, or nursing hotlines.

^cHearing benefits may include coverage for hearing tests, hearing aid fittings, and hearing aid evaluations.

^dInpatient stays and skilled nursing facility stays may include additional days beyond what Medicare FFS covers.

^eVision benefits may include coverage for routine eye exams, contacts, or eyeglasses (lenses and frames).

The average projected dollar amount of the common additional benefits across all MA plans ranged from \$0.11 PMPM for international outpatient emergency services to \$4 PMPM for dental care. These estimates were based on the subset of plans that provided cost projections in the

categories associated with the benefits. The number of plans included in the averages varies from the number of plans offering the benefits in part because some plans did not consistently include the same additional services in the same benefit categories. For example, some plans categorized all or part of the costs associated with additional vision benefits in other categories, such as professional services.¹⁶ These estimates are also based on plans' reported funding for additional benefits from both rebates and additional premiums. Had we limited our analysis to additional benefits funded only from rebates, the estimated amounts of the additional benefits would have been lower. On the basis of plan projections, we estimated that rebates would pay for most of the additional benefits plans provided (77 percent), while additional premiums would pay for the remainder (23 percent). Table 3 provides a summary of the projected costs of additional benefits.

Table 3: Average Projected PMPM Costs of Additional Benefits by Service Category and Plan Type for Plans That Offered Benefits and Reported Costs, 2007

	HMO		PFFS		PPO		All plans ^a	
	Number of plans	Average cost (PMPM)	Number of plans	Average cost (PMPM)	Number of plans	Average cost (PMPM)	Number of plans	Average cost (PMPM)
Dental ^b	435	\$3.72	29	\$4.34	80	\$5.79	555	\$4.00
Health education ^b	641	2.01	97	1.12	165	1.95	905	1.89
Hearing ^b	895	0.86	185	0.97	235	1.51	1301	0.92
Inpatient stays ^b	995	1.74	255	1.31	240	1.75	1482	1.69
International outpatient emergency	838	0.13	185	0.05	204	0.06	1083	0.11
Skilled nursing facility stays ^b	576	1.33	119	0.38	94	1.55	801	1.14
Vision ^b	1,076	3.41	182	2.37	280	5.76	1558	3.37

Source: GAO analysis of 2007 CMS fee pricing data.

Notes: Dollar amounts are weighted by August 2007 plan enrollment and are standardized to represent a beneficiary of average health status. We considered an MA plan to have covered an additional benefit if it projected that it would allocate at least \$.01 PMPM of revenue to the additional benefit. Employer plans, Part B only plans, SNPs, regional PPOs, and plans with service areas that are exclusively outside of the 50 states and the District of Columbia were excluded from the analysis.

¹⁶ Some categories were identified by CMS as unreliable and were excluded from our analysis.

*The "All plans" category includes HMOs, PFFS plans, PPOs, and PSOs. Results are not reported separately for PSOs because there are only 22 PSO plans and enrollment in those plans constituted 1 percent of total MA enrollment.

*Dental benefits may include oral exams, tooth cleanings, fluoride treatments, dental X-rays, or emergency dental services.

*Health education benefits may include nutritional training, smoking cessation, health club memberships, or nursing hotlines.

*Hearing benefits may include coverage for hearing tests, hearing aid fittings, and hearing aid evaluations.

*Inpatient stays and skilled nursing facility stays may include additional days beyond what Medicare FFS covers.

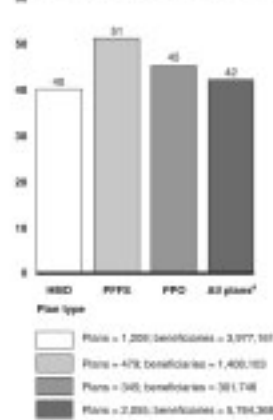
*Vision benefits may include coverage for routine eye exams, contacts, or eyeglasses (frames and lenses).

MA Plans Projected That MA Beneficiaries, on Average, Would Have Lower Cost Sharing Than if They Were in Medicare FFS, but Some MA Beneficiaries Could Pay More

For 2007, MA plans projected that MA beneficiary cost sharing would be 42 percent of estimated cost sharing in Medicare FFS. (See fig 3.) Plans projected that their beneficiaries, on average, would pay \$49 PMPM in cost sharing, and they estimated that Medicare FFS equivalent cost sharing for their beneficiaries was \$116 PMPM. On the basis of plans' projections, we estimated that about 77 percent of the reduction in beneficiary cost sharing was funded by rebates with the remainder being funded by additional beneficiary premiums.

Figure 3: Average Projected Cost Sharing for MA Beneficiaries Compared to Their Cost Sharing in Medicare FFS, by Plan Type, 2007

Percentage of Medicare FFS cost-sharing estimate



Source: OIG analysis of 2007 CMS/DOHHS MA data.

Notes: Employer plans, Part B only plans, SNPs, regional PPOs, and plans with service areas that are exclusively outside of the 56 states and the District of Columbia were excluded from the analysis. Numbers are weighted by August 2007 plan enrollment.

^aThe "All plans" category includes HMOs, PFFS plans, PPOs, and PSOs. Results are not reported separately for PSOs because there were only 22 PSO plans and enrollment in those plans constituted 1 percent of total MA enrollment.

Although plans projected that beneficiaries' overall cost sharing was lower, on average, than Medicare FFS cost-sharing estimates, some MA plans projected that cost sharing for certain categories of services was higher than Medicare FFS cost-sharing estimates. For example, 19 percent of MA beneficiaries were enrolled in plans that projected higher cost sharing for home health services, on average, than Medicare FFS, which has no cost sharing for this service at all, and 16 percent of beneficiaries were enrolled in plans that projected higher cost sharing for inpatient.

services compared to Medicare FFS estimates.²² (See table 4.) Because cost sharing is higher for some categories of services, some beneficiaries who frequently use these services can have overall cost sharing that is higher than what they would pay under Medicare FFS.

Table 4: Beneficiaries in MA Plans with Higher Projected Cost Sharing Than Medicare FFS for a Given Service Category by Plan Type, 2007

	HMO Plans = 1,288 Beneficiaries = 3,577,161		PFFS Plans = 476 Beneficiaries = 1,400,103		FFO Plans = 345 Beneficiaries = 301,746		All plans ^a Plans = 2,068 Beneficiaries = 5,764,350	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Home health services ^b	422,078	11	393,523	28	253,242	94	1,069,023	19
Inpatient services ^c	696,763	19	170,737	12	66,746	22	937,246	16
Skilled nursing facility services	384,960	10	67,017	5	47,094	16	499,071	9
Durable medical equipment, prosthetics, and supplies	60,070	2	110,147	8	13,324	4	215,541	4
Part B drugs ^d	66,458	2	7,975	1	4,806	2	101,416	2
Outpatient facility services ^e	31,369	1	0	0	138	0	31,497	1
Professional services ^f	14,641	0	5,781	0	28,611	9	47,033	1

Source: GAO review of 2007 CMS data using 1-year data.

Notes: Employer plans, Part B only plans, SNPs, regional PPOs, and plans with service areas that are exclusively outside of the 50 states and the District of Columbia were excluded from the analysis.

^aThe "All plans" category includes HMOs, PFFS plans, FFOs, and PSOs. Results are not reported separately for PSOs because there were only 22 PSO plans and enrollment in these plans constituted 1 percent of total MA enrollment.

^bHome health services include skilled nursing services, home health aides, and certain therapy services, all provided in the home setting.

^cMany MA plans include cost sharing for professional services, such as physician visits received during a hospital stay, in their inpatient cost-sharing amount. As a result, the cost sharing for professional services may be understated for MA plans, while the inpatient cost sharing may be overstated for MA plans. Professional services include physician visits, therapy, and radiology, among other services.

²²Average cost sharing reflects expenditures for the entire population and includes both beneficiaries who are projected to use a certain category of service and beneficiaries who are not projected to use that service.

Part B drugs are drugs that are covered under Medicare Part B, and they include drugs that are typically administered by a physician. Many plans excluded Part B drugs from the out-of-pocket maximum if they were obtained from a pharmacy, but according to CMS, did not exclude Part B drugs administered by a physician.

*Outpatient facility services include surgery, emergency, and other services provided in an outpatient facility.

Cost sharing for particular categories of services varied substantially among MA plans. For example, we found significant variation in cost sharing for inpatient services. Some MA beneficiaries were in plans with no cost sharing for inpatient services. More than half a million MA beneficiaries, representing 9 percent of MA beneficiaries, were in 133 plans with no deductibles, copayments, or coinsurance requirements for inpatient services as of August 2007. Beneficiaries in these plans with long or frequent hospital stays could have saved thousands compared to what their cost sharing would have been if they were enrolled in Medicare FFS, which typically included a \$802 deductible, a \$348 daily copayment for hospital stays lasting between 61 and 90 days, and additional coinsurance payments for professional services provided in the hospital.²⁴

Other MA beneficiaries, however, could have paid substantially more than Medicare FFS beneficiaries for inpatient care. We found 80 MA plans that charged a daily copayment of \$200 or more for the first 10 days of a hospital admission and placed high or no limits on out-of-pocket costs for inpatient services.²⁵ These 80 MA plans also had more than half a million beneficiaries. Beneficiary cost sharing in these 80 plans could have been \$2,000 or more for a 10-day hospital stay, and \$3,000 or more for three

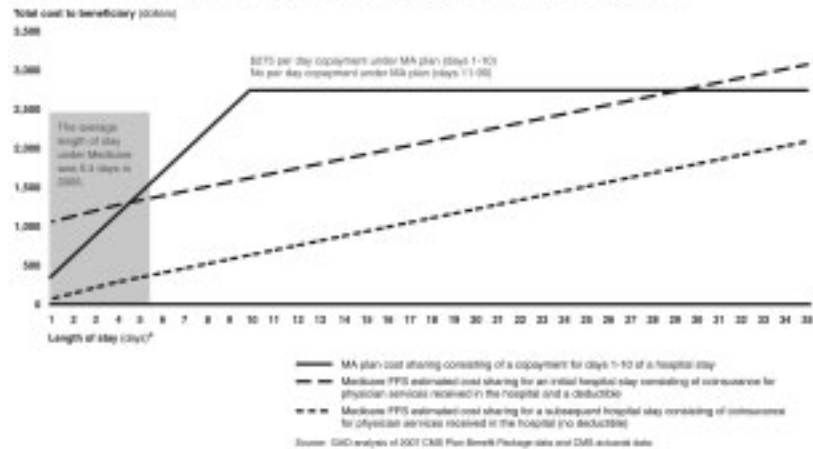
²⁴Medicare FFS beneficiaries could have paid the deductible more than once for multiple visits under some circumstances. The 2007 deductible was \$802 for each benefit period. Under Medicare FFS, a benefit period begins the day a beneficiary enters a hospital, skilled nursing facility, or critical access hospital, and it ends when the beneficiary has not been an inpatient of a hospital, skilled nursing facility, or critical access hospital for 60 consecutive days. A Medicare FFS beneficiary who had three hospital stays in one benefit period in 2007 would have paid a \$802 deductible, while a beneficiary who had three hospital stays in three separate benefit periods would have paid a \$802 deductible for each hospital stay, or \$2,406.

²⁵The plans either had no out-of-pocket maximum or had a maximum that was above \$3,100. In addition, the plans had no service-specific maximums for inpatient services.

average-length hospital stays.²⁸ Figure 4 provides an illustrative example of an MA plan that could have exposed a beneficiary to higher inpatient costs than under Medicare FFS. While the plan in this illustrative example had lower cost sharing than Medicare FFS for initial hospital stays of 4 days or less as well as initial hospital stays of 30 days or more, for stays of other lengths the MA plan could have cost beneficiaries more than \$1,000 above out-of-pocket costs under Medicare FFS. The disparity between out-of-pocket costs under the MA plan and costs under Medicare FFS was largest when comparing additional hospital visits in the same benefit period, since Medicare FFS does not charge a deductible if an admission occurs within 60 days of a previous admission.

²⁸The average length of stay in Medicare FFS was 5.4 days in 2006, according to a MedPAC analysis of Medicare cost report data. For plans with no out-of-pocket maximum and a per day copayment of \$200 or more for the first 10 hospital days, beneficiaries would have been billed at least \$2,000 for a 30-day hospital stay and at least \$3,000 for three stays that are each 5 days long. However, beneficiaries in plans with an out-of-pocket maximum and a per day copayment of \$200 or more could have been billed less than these amounts if they had already paid cost sharing for other categories of services. About 15 percent of hospital stays under Medicare lasted 10 days or more in 2004, according to CMS data.

Figure 4: Example of an MA Plan with Inpatient Cost Sharing Different from the Medicare FFS Program



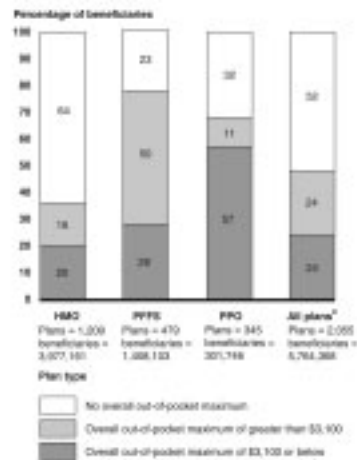
Notes: In this example, the MA plan charged a \$275 daily copayment for the first 10 days of the hospital stay, and charged no additional copayment for days 11 through 90. The plan had a \$4,000 out-of-pocket maximum. In contrast, in 2007 Medicare FFS charged a \$960 deductible for an initial hospital stay in a benefit period and \$248 per day for days 61 through 90 of a hospital stay. Medicare FFS beneficiaries paid no deductible for a subsequent hospital stay if it occurred within 90 days of the previous stay in an inpatient facility. In addition, Medicare FFS beneficiaries must pay coinsurance for physician services received while in the hospital. The charges associated with these physician services averaged \$73 per day for the first 4 days of the hospital stay, and \$50 per day for the remaining days of a hospital stay through 90 days. This example assumes that the beneficiary was charged the average coinsurance. The actual amount of coinsurance a beneficiary pays varies based on the amount of services a beneficiary receives, and charges can be above or below the average.

^aNearly 68 percent of hospital stays under Medicare were 10 days or less in 2004 according to CMS data. About 3 percent of hospital stays were 30 days or longer, and 1 percent of stays were longer than 30 days.

As of August 2007, about 48 percent of MA beneficiaries were enrolled in plans that had an out-of-pocket maximum, which helps protect beneficiaries against high spending on cost sharing.²⁷ (See fig. 5.) Of the three most common MA plan types, beneficiaries in PFFS plans were the most likely to be in a plan with an out-of-pocket maximum, but PFFS plans also had the highest average out-of-pocket maximum. For MA plans that had an out-of-pocket maximum, the average amount was \$3,463. See appendix IV for further details on out-of-pocket maximums.

²⁷Medicare FFS does not have an out-of-pocket maximum. However, Medicare FFS beneficiaries who have supplemental insurance can have some or all of their cost sharing paid for. Medicare FFS beneficiaries who buy Medigap insurance have their Part A and Part B cost sharing paid for by their Medigap plan, although they still may pay deductibles. Medicare FFS beneficiaries with Medicaid and with employer plans can also have some or all of their cost sharing paid for by their plan. As of 2004, 26 percent of Medicare beneficiaries had Medigap insurance, 17 percent had Medicaid, and 38 percent had employer insurance, with some beneficiaries having more than one type of supplemental insurance. Data are based on MedPAC's analysis of the 2004 Medicare Current Beneficiary Survey.

Figure 5: Beneficiaries in MA Plans by Out-of-Pocket Maximum Amount and Plan Type, 2007



Source: SAG analysis of 2007 CMS Bid Pricing Test data.

Notes: For 2007, CMS generally applied less stringent criteria in evaluating a plan's cost-sharing requirements if the plan had an out-of-pocket maximum of \$3,100 or below. If a plan had two out-of-pocket maximums—one for in-network services and one for contracted in- and out-of-network services, then we used the lower value for this analysis. Some plans without an out-of-pocket maximum did have a service-specific maximum. Twenty-one percent of plans with no out-of-pocket maximum had a service-specific maximum for inpatient acute services, and 18 percent of plans with no out-of-pocket maximum had a service-specific maximum for inpatient psychiatric services. Employer plans, Part B only plans, SNPs, regional PPOs, and plans with service areas that are exclusively outside of the 50 states and the District of Columbia were excluded from the analysis. Some numbers do not add up to 100 due to rounding.

*The "All plans" category includes HMOs, PFFS plans, PPOs, and PGOs. Results are not reported separately for PGOs because there were only 22 PGO plans and enrollment in those plans constituted 1 percent of total MA enrollment.

An out-of-pocket maximum does not always cover all categories of services. Some MA plans excluded some services from the out-of-pocket maximum. Beneficiaries who use these excluded services may pay more in total cost sharing than is indicated by the plan's out-of-pocket maximum. Part B drugs, which include drugs that are typically physician-

administered drugs, were most often excluded from the out-of-pocket maximum—29 percent of MA plans with an out-of-pocket maximum excluded some Part B drugs from that maximum.²⁹ (See table 5.) Plans that excluded a certain service category from the out-of-pocket maximum did not necessarily exclude all services from that category. For example, many plans excluded Part B drugs from the out-of-pocket maximum if they were obtained from a pharmacy, but according to CMS, did not exclude Part B drugs administered by a physician.

Table 5: MA Plans That Exclude Some Services under a Service Category from Their Out-of-Pocket Maximum

	Number of plans Plans = 1,016	Percentage of plans Plans = 1,016	Number of beneficiaries Beneficiaries = 2,738,531	Percentage of beneficiaries Beneficiaries = 2,738,531
Part B drugs ^a	296	29	1,107,876	40
Outpatient substance abuse	255	25	645,997	24
Physician specialist, excluding psychiatric	230	23	641,270	23
Mental health, non-psychiatric	220	22	630,504	23
Psychiatric	216	21	602,900	22
Home health services	211	21	599,618	21
Prosthetics and medical supplies	128	13	603,952	22
Durable medical equipment	116	11	565,413	21
Outpatient hospital	72	7	192,182	7
Inpatient hospital, psychiatric	37	4	149,105	5
Skilled nursing facility	34	3	100,700	4
Inpatient hospital, acute	19	2	28,937	1

Source: GAO analysis of 2009 CMS Plan Benefit Package data.

Notes: We considered an MA plan to have an out-of-pocket maximum if the plan had either an in-network out-of-pocket maximum or an out-of-pocket maximum for both in-network and out-of-network services. A plan was considered to have excluded a service category from the out-of-pocket maximum if the out-of-pocket maximum did not cover that service category and if the plan had no service-specific maximum for that category. Plans that excluded a certain service category from the out-of-pocket maximum did not necessarily exclude all services from that category. HMOs, PFFS plans, PPOs, and PBOs were included in the analysis. Employer plans, Part B only plans, SNPs, regional PPOs, and plans with service areas that were exclusively outside of the 50 states and the District of Columbia were excluded from the analysis. Only plans with an out-of-pocket maximum were included in this analysis.

²⁹A plan was considered to have excluded a service category from the out-of-pocket maximum if the out-of-pocket maximum did not cover that service category and if the plan had no service-specific maximum for that category.

¹⁶Many plans excluded Part B drugs from the out-of-pocket maximum if they were obtained from a pharmacy, but according to CMS, did not exclude Part B drugs administered by a physician.

**Approximately
87 Percent of Total
Revenue Projected to
Be Allocated to
Medical Expenses,
but Projections Varied
among Individual
Plans**

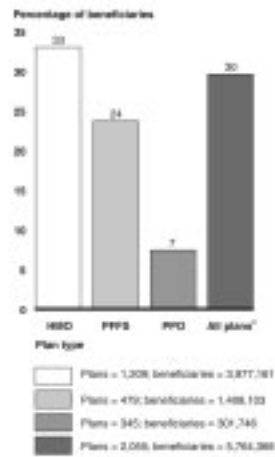
For 2007, MA plans projected that of their total revenues (\$783 PMPM), they would allocate approximately 87 percent (\$683 PMPM) to medical expenses, resulting in an average medical loss ratio of approximately 0.87. MA plans projected that they would allocate approximately 9 percent of total revenue (\$71 PMPM) to non-medical expenses, and approximately 4 percent (\$30 PMPM) to the plans' margin, on average.¹⁶

While there was little variation in the average projected medical loss ratio by plan type, there was variation among individual plans. For example, we found that about 30 percent of beneficiaries—about 1.7 million—were enrolled in plans with a medical loss ratio of less than 0.85—the threshold included in the Children's Health and Medicare Protection Act of 2007 (CHAMP Act).¹⁷ (See fig. 6.) A CMS official we spoke to stated that the medical loss ratio may vary for reasons other than utilization and the cost of providing care. For example, some MA plans may categorize the costs of delivering care management services as a medical expense, while other plans may include this as a non-medical expense.

¹⁶Non-medical expenses include administration, marketing, and sales. Margin is the amount of revenue above or below the revenue needed to cover medical and non-medical expenses. Allocations to medical expenses, non-medical expenses, and margins do not add to \$783 PMPM due to rounding.

¹⁷There is no definitive standard for what a medical loss ratio should be. For example, the CHAMP Act, H.R. 3162, 110th Cong., § 414 (2007), which was passed in the House of Representatives on August 1, 2007, included a medical loss ratio threshold of 0.85. In contrast, individual Medicaid policies are currently required to achieve a medical loss ratio of at least 0.65, while group Medicaid policies are required to achieve a medical loss ratio of at least 0.75. AHP reported that from 1990 to 2003, the medical loss ratio for private plans averaged about 0.86.

Figure 5: Percentage of Beneficiaries in MA Plans That Project Allocating Less Than 85 Percent of Total Revenues to Medical Expenses, by Plan Type, 2007



Source: GAO analysis of 2007 CMS Bid Pricing Tool data.

Notes: A CMS official indicated that the percentage of revenues allocated to medical expenses (the medical loss ratio) may vary across plans for reasons other than utilization and the cost of providing care. For example, some MA plans may categorize the costs of delivering case management services as a medical expense, while other plans may include this as a non-medical expense. Employer plans, Part D only plans, SNPs, regional PPOs, and plans with service areas that are exclusively outside of the 50 states and the District of Columbia were excluded from the analysis.

*The "All plans" category includes HMOs, PFFS plans, PPOs, and POCs. Results are not reported separately for POCs because there were only 22 POC plans and enrollment in these plans constituted 1 percent of total MA enrollment.

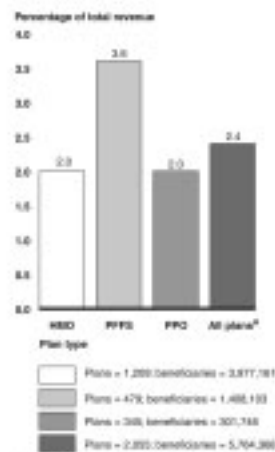
MA plans projected expenses separately for four distinct non-medical expense categories—marketing and sales, direct administration, indirect administration, and the net cost of private reinsurance.³ On average, MA plans projected allocating total revenue to non-medical expenses approximately as follows:

- 2.4 percent to marketing and sales;
- 2.9 percent to direct administration, such as customer service and medical management;
- 3.7 percent to indirect administration, such as accounting operations and human resources; and
- 0.1 percent to the net cost of private reinsurance.

Of these four non-medical expense categories, the largest difference between plan types' allocation of revenue to non-medical expenses was in the category of marketing and sales. On average, as a percentage of total revenue, projected marketing and sales expenses were 2 percent (\$16 PMPM) for HMOs, 3.6 percent (\$27 PMPM) for PFFS plans, and 2 percent (\$17 PMPM) for PPOs. (See fig. 7.)

³Direct administration accounts for functions that are directly related to the administration of the MA program, such as customer service and medical management. Indirect administration accounts for functions that may be considered "corporate services," such as accounting operations and human resources. Private reinsurance is the insurance provided by another company that assumes financial risk previously assumed by the MA plan. The net cost of private reinsurance is equal to the reinsurance premium less projected reinsurance recoveries.

Figure 7: MA Plans' Projected Marketing and Sales Expenses by Plan Type, 2007



Source: GAO analysis of 2007 GAO Office of the Inspector General data.

Notes: Percentages are weighted by August 2007 enrollment. Employer plans, Part B only plans, SNPs, regional PPOs, and plans with service areas that are exclusively outside of the 50 states and the District of Columbia were excluded from the analysis.

*The "All plans" category includes HMOs, FFFS plans, PPOs, and PSOs. Results are not reported separately for PSOs because there were only 32 PSO plans and enrollment in those plans constituted 1 percent of total MA enrollment.

Concluding Observations

Medicare spends more per beneficiary in MA than it does for beneficiaries in Medicare FFS, at an estimated additional cost to Medicare of \$54 billion from 2009 through 2012. Under the current payment system, the average MA plan receives a Medicare rebate equal to approximately 887 PMPM, on average. In 2007, MA plans projected that they would use the vast majority of their rebates—approximately 80 percent—to reduce enrollees' premiums and to lower their out-of-pocket costs for Medicare-covered services. Plans projected that they would use a relatively small portion of their rebates—approximately 11 percent—to provide benefits that are not

covered under Medicare FFS. Although the rebates generally have helped to make health care more affordable for many beneficiaries enrolled in MA plans, some beneficiaries may face higher expenses than they would in Medicare FFS. Further, because premiums paid by beneficiaries in Medicare FFS are tied to both Medicare FFS and MA costs, the additional payments to MA plans have increased the premiums paid by beneficiaries in Medicare FFS as well as contributed to the substantial long-term financial challenge that Medicare faces. Whether the value that MA beneficiaries receive in the form of reduced cost sharing, lower premiums, and extra benefits is worth the increased cost borne by beneficiaries in Medicare FFS and other taxpayers is a decision for policymakers. However, if the policy objective is to subsidize health care costs of low-income Medicare beneficiaries, it may be more efficient to directly target subsidies to a defined low-income population than to subsidize premiums and cost sharing for all MA beneficiaries, including those who are well off. As Congress considers the design and cost of the MA program, it will be important for policymakers to balance the needs of beneficiaries—including those in MA plans and those in Medicare FFS—with the necessity of addressing Medicare's long-term financial health.

Agency and Other External Comments and Our Evaluation

CMS provided us with written comments on a draft of this report which are reprinted in appendix V, and AHIP, a national association that represents companies providing health insurance coverage, provided us with oral comments.

CMS Comments

In general, CMS commented that the report did not recognize that the majority of MA benefit packages in 2007 were better and provided more protection for out-of-pocket costs than Medicare FFS. It stated that the report failed to acknowledge that MA plans provide beneficiaries with the ability to choose a plan that best meets individual medical and financial needs. CMS also expressed concern that the report was not balanced because it did not sufficiently focus on the advantages of MA plans. We disagree with CMS that we did not consider that most MA plans offered better cost sharing than Medicare FFS. We noted in the first paragraph of our cost sharing finding that, overall, plans projected MA beneficiary cost sharing that was 42 percent of estimated cost sharing in Medicare FFS. Regarding the absence of information about MA plans providing beneficiaries with choices, this was not the focus of our research. However, we agree the issue provides important context and therefore we noted in the report's introduction the additional choice MA plans provide Medicare beneficiaries. We disagree that the report is not balanced. We

provided a fact-based assessment of how rebates were projected to be used in 2007, and identified important issues related to cost sharing. Even though cost sharing would be less, on average, in MA plans than in Medicare FFS, an important finding of our report is that beneficiaries who use certain services with high cost sharing in MA plans could have higher overall out-of-pocket costs than under Medicare FFS.

CMS provided several additional comments. CMS commented that it did not disagree with our finding that 10 percent of beneficiaries were in plans with higher inpatient cost sharing than Medicare FFS. However, it noted that our discussion of the issue and accompanying table and figure did not account for several factors that would have mitigated the impact of the finding. Specifically, CMS commented that we should have considered that MA plans generally combine physician cost sharing in the hospital with inpatient hospital cost sharing, which would have decreased the difference in cost sharing between MA plans and Medicare FFS. Although we had noted this in table notes in the draft, we agree that this should be clearer and modified our text and accompanying figure comparing MA and Medicare FFS cost sharing, and clarified existing table notes. We also modified the text and accompanying figure to differentiate between first and subsequent admissions within the same benefit period, in response to CMS comments. These changes did not affect our finding that some beneficiaries could have cost sharing that was considerably higher than in Medicare FFS.

CMS also commented that we should have discussed the mitigating impact of particularly long hospitalizations because beneficiaries with long inpatient hospital stays in MA plans are likely to have lower cost sharing than under Medicare FFS. We acknowledged CMS's point and addressed this issue in the finding and modified the accompanying figure. However, most beneficiaries have relatively short lengths of stay. For example, in 2006, the average length for an inpatient stay was 5.4 days. This modification did not change our message that some beneficiaries in MA plans could have higher out-of-pocket costs.

In addition, CMS commented that we should have noted that many plans have "effective" out-of-pocket maximums for inpatient stays even if they are not specified as such in the plan benefit package. For example, plans may require copayments for specific days of an inpatient stay, such as days 1 through 6, but not for any days beyond the sixth day, thereby capping maximum cost sharing for the stay. We agree that most plans have "effective" or actual out-of-pocket maximums for inpatient hospital services. We also agree that in many cases these maximums can limit

beneficiary inpatient cost sharing to levels below inpatient cost sharing under Medicare FFS. However, MA plans projected that about 16 percent of beneficiaries were enrolled in plans that projected higher cost sharing than under Medicare FFS even after accounting for "effective" or actual out-of-pocket maximums. While some of the 16 percent of plans may have bundled physician services with their inpatient estimates, we also showed that 80 plans with high out-of-pocket maximums for inpatient services could have higher cost sharing than Medicare FFS even with "effective" out-of-pocket maximums for inpatient hospital services.

CMS raised other concerns about our out-of-pocket maximum analysis, specifically stating that we overestimated the impact of the exclusion of Part B drugs from out-of-pocket maximums. It noted that Part B drugs administered in a physician's office would be included under an out-of-pocket maximum and that only a subset of plans excluded Part B drugs obtained from a pharmacy from the out-of-pocket maximum. We relied on the Plan Benefit Package for information regarding the analysis of Part B drug exclusions from out-of-pocket maximums. According to these data, there were 1.1 million beneficiaries in plans that reported such exclusions in 2007. We noted that the exclusions applied to Part B drugs obtained from a pharmacy and that the plans did not indicate the coverage for Part B drugs administered by a physician. We sought clarification from CMS for which Part B drugs were excluded from the out-of-pocket maximum and were told by a CMS official that plans excluded spending on Part B drugs from the out-of-pocket maximum if beneficiaries received them on an outpatient basis. We added this point of clarification to a footnote in the draft. Given CMS's subsequent agency comments on this issue, we clarified in the text that the exclusions applied to Part B drugs obtained from a pharmacy and do not typically apply to Part B drugs administered by a physician. However, we are concerned that the information in the Plan Benefit Package—information that beneficiaries rely on when they are seeking benefit coverage information—does not indicate whether chemotherapy drugs are included or excluded under the out-of-pocket maximums.

CMS also provided technical comments and clarifications, which we incorporated as appropriate.

AHIP Comments

AHIP representatives stated that they agreed with our methodology, but raised certain points that they thought the report should have made or emphasized.

AHIP representatives said that while they understood why we made a distinction between additional benefits and cost-sharing reductions, they believed that we characterized additional benefits as being the more valuable of the two. We disagreed with AHIP's assessment. While we did include a discussion of how MA plans projected they would allocate their rebates to additional benefits, premium reductions, and cost-sharing reductions, it was beyond the scope of our work to assess the relative value of the allocation options.

With regard to our cost-sharing finding, AHIP stated that while MA beneficiaries may have higher cost sharing for some categories of services, these may be offset by lower cost sharing for other categories of services. Like CMS, AHIP contended that our example of an MA plan with higher cost sharing for inpatient services, relative to FFS, did not account for the additional cost sharing Medicare FFS beneficiaries would pay for physician services during their inpatient stays. As both CMS and AHIP pointed out, most MA plans do not charge extra for physician services during inpatient stays. We have made changes to the text of our report and the accompanying figure to clarify this point. However, as our report noted, beneficiaries who frequently use high cost-sharing services could have overall cost sharing that would be higher than under Medicare FFS.

AHIP stated that although some beneficiaries may face higher cost sharing under an MA plan than if they were enrolled in Medicare FFS, their out-of-pocket costs could be lower if their MA plan has a lower premium than Medicare FFS. While this may be true in some cases—we found that, on average, plans used 3 percent of their rebates to reduce Part B premiums—it was beyond the scope of our work to make such a determination. AHIP further stated that MA plans provide beneficiaries with options. Beneficiaries who prefer more predictable expenses can choose MA plans with higher premiums and lower cost sharing, while beneficiaries who are less averse to risk can choose MA plans with lower premiums and higher cost sharing. We agree that the MA program provides beneficiaries with options and have added this point to the text of our report.

With regard to our reporting on MA plan medical loss ratios, AHIP representatives indicated that our point was fairly stated, but they asked us to mention this point in the Results in Brief section of the report. We believed that we made this point clear in our discussion of medical loss ratios and that the issue did not warrant mentioning in our high-level summary.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from its date. At that time we will send copies to the Administrator of CMS and interested congressional committees. We will also make copies available to others upon request. The report will also be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staffs have any questions about this report please contact me at (202) 512-7114 or cosgrove@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VI.



James C. Cosgrove
Acting Director, Health Care

List of Requesters

The Honorable John D. Dingell
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Frank Pallone, Jr.
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
House of Representatives

The Honorable Charles B. Rangel
Chairman
Committee on Ways and Means
House of Representatives

The Honorable Pete Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Appendix I: Example of a Rebate Calculation

For most Medicare Advantage (MA) plan types, Medicare provides plans with a rebate if the plan's bid is below the benchmark, but provides no rebate if the plan's bid exceeds the benchmark.¹ Table 6 is an example of rebate calculations for two hypothetical plans, both in the same county.

Table 6: The Calculation of the Rebate for Two Hypothetical MA Plans

	Plan A dollars per member per month	Plan B dollars per member per month
County's fee-for-service spending	\$720	\$720
County's benchmark	800	800
Plan bid	790	840
Amount by which bid is lower than benchmark	100	0
Plan's rebate (75 percent of amount by which bid is lower than benchmark)	75	0
Medicare payment	775	800
Mandatory plan premium	0	40
Additional benefits, reduced premiums, and reduced cost sharing to beneficiary	75	0

Source: GAO.

Note: All numbers in this example are standardized to represent a beneficiary of average health status.

Both plans have the same benchmark because they are in the same county. Plan A submits a bid of \$790 per member per month (PMPM). Because the plan's bid is \$100 PMPM below the benchmark, it receives a rebate equal to 75 percent of that amount, or \$75 PMPM. Plan A must use the \$75 PMPM rebate to provide additional benefits, reduced premiums, reduced cost sharing, or any combination of the three. Plan B, however, submits a bid that is \$40 PMPM above the benchmark. As a result, the plan receives no rebate. Medicare's payments to plans cannot exceed the benchmark, so Medicare's payment to Plan B is set at \$800 PMPM, the amount of the benchmark. Plan B must make up the remainder of the bid by charging its beneficiaries a mandatory plan premium of \$40 PMPM. Since Plan A has

¹For Medical Savings Account (MSA) plans, Medicare makes a deposit into a beneficiary's savings account if the bid is lower than the benchmark, instead of providing the plan with a rebate. Regional Preferred Provider Organizations (RPOs) can receive rebates, but their benchmarks are determined differently than local plans. Due to these differences, the example in this appendix does not refer to MSA plans and regional RPOs.

Appendix B: Example of a Rebate Calculation

extra benefits and no additional premium, while Plan B has no extra benefits and an additional premium, Plan A may attract more beneficiaries. If most beneficiaries choose Plan A over Plan B, Plan B is given an incentive to become more efficient in the following year and lower its bid.

Appendix II: Scope and Methodology

This section describes the scope and methodology used to analyze our four objectives: (1) how MA plans projected they would allocate the rebates they receive, (2) what additional benefits MA plans commonly covered with the rebates and additional premiums, and the projected costs of these additional benefits, (3) how MA plans' projected beneficiary cost sharing, overall and by type of service, compared to Medicare fee-for-service (FFS), and (4) how MA plans projected they would allocate their revenue to medical and other expenses.

We used two primary data sources to analyze our four objectives: the 2007 Bid Pricing Tool data and the 2007 Plan Benefit Package data. These data are submitted by MA plans to the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare. The bid pricing data contain MA plans' projections of their revenue requirements and revenue sources. Specifically, the bid pricing data include MA plans' projections of revenue requirements—spending on medical expenses, spending on non-medical expenses, and the margin. The bid pricing data also contain information on the benefits and cost-sharing arrangements of plans, including how MA plans' projected cost sharing compares to cost sharing in Medicare FFS. In addition, the bid pricing data contain information on the amount of rebates and additional premiums plans project they will require to fund additional benefits, reduced premiums, and reduced cost sharing. The benefit package data contain detailed information about the benefits and cost-sharing requirements that MA plans offer to Medicare beneficiaries.

For our objectives, we focused our analysis on plan types that account for 98 percent of MA enrollment: Health Maintenance Organizations (HMO) (71 percent), Private Fee-for-Service (PFFS) Plans (21 percent), Preferred Provider Organizations (PPO) (5 percent), and Provider-Sponsored Organizations (PSO) (1 percent).¹ We excluded Medical Savings Account plans and regional PPOs from our analysis because they follow a different bidding process. We excluded plan types that have unique restrictions on enrollment—such as employer plans, Special Needs Plans (SNP), and demonstration plans—and bids for plans that only cover Part B services. We also excluded plans with service areas that are exclusively outside the 50 states and the District of Columbia. Plans sponsors are permitted to submit separate bids for a single package of benefits by dividing the service area into segments; in these cases, benefits would be the same for

¹Percentage of MA enrollment by plan type is based on August 2007 enrollment.

each segment, but each segment's cost sharing and premiums may differ. We counted each segment as a separate plan. We used August 2007 enrollment numbers to weight our results. As a result of our methodology, we included 2,055 plans and 5,764,988 beneficiaries (71 percent of total MA enrollment) in our analysis—these numbers apply to all tables and figures in the report, unless otherwise noted. Because there were only 22 PSCOs after the exclusions, and enrollment in those plans was 1 percent of MA enrollment, we do not report results separately for PSCOs, but we include them in the aggregated results we report for all MA plans.

To determine how plans projected they would allocate the rebate to additional benefits, reduced premiums, and reduced cost sharing, we used the bid pricing data. The bid pricing data contain the total amounts plans projected they would spend on additional benefits, reduced premiums, and reduced cost sharing. However, since MA plans use both rebates and additional premiums as a funding source for these additional benefits, reduced premiums, and reduced cost sharing, we calculated the proportion of total funding plans projected they would spend on additional benefits, reduced premiums, and reduced cost sharing and applied these projections to the projected rebate. We restricted our analysis of rebate allocations to the 1,874 plans that received a rebate.

To identify the additional benefits that MA plans commonly covered with rebates and additional premiums, we used the benefit package data. The benefit package data provide the most detailed and accurate information about benefits offered, including additional benefits. We used the crosswalk CMS recommended—but did not require—plans to use to match service categories in the benefit package data to categories in the bid pricing data, and identified the percentage of beneficiaries in plans that offered additional benefits using bid pricing categories.¹

To identify the costs associated with these additional benefits, we used the bid pricing data. Plans did not use consistent categories for their additional benefits in the bid pricing data. For example, some plans categorized additional vision benefits under the category of other non-covered services. Therefore, our estimates of the costs of additional benefits do not include all plans that offer those benefits, but are based on a smaller number of plans that specified that additional benefit and the

¹Centers for Medicare & Medicaid Services, *Instructions for Completing the Medicare Advantage Bid Pricing Tool For Contract Year 2007* (Baltimore, Md: May 2006).

associated cost of providing that benefit. In addition, some categories, such as professional services and other non-covered services, were identified by CMS as unreliable because they likely included a variety of services, and we excluded these categories from our analysis. Other categories of additional services may include some inconsistent services, and the cost estimates for additional benefits should therefore be considered as approximations.

To calculate estimated costs for each of the additional service categories, we identified plans that offered the additional benefit and that had projected a cost of at least \$0.01 PMPM. The projected amounts of plans' additional benefits were adjusted for the health status of the plans' projected population by dividing the amount of the plans' additional benefits by the plans' projected risk scores—a number representing how a plan's beneficiaries' health expenditures are predicted to differ from the average beneficiary in Medicare FFS.³ We then calculated the average amount of the additional benefit, weighting the average by the number of enrollees in the plans. If we had estimated the amount of additional benefits funded only by the rebates, the PMPM amounts of additional benefits would be lower.

To compare projected beneficiary cost sharing in MA plans and Medicare FFS, we analyzed plans' cost sharing for Medicare-covered services as reported in the bid pricing data and the equivalent Medicare FFS cost-sharing amounts, also included in the bid pricing data. The equivalent Medicare FFS cost sharing represents an MA beneficiary's expected cost sharing under Medicare FFS if the beneficiary's MA plan had the same pricing and utilization as Medicare FFS. The Medicare FFS equivalent cost sharing for each service category was calculated by applying the average cost-sharing percentage under Medicare FFS for a given service category to each plan's total cost estimates for providing benefits in that service category. For example, if the cost-sharing percentage under Medicare FFS for inpatient services is 10 percent for a given county, and an MA plan in that county projects spending on inpatient services at \$200 PMPM, then the equivalent inpatient cost sharing is 10 percent of \$200, or \$20 PMPM. For Part A services, the cost-sharing percentage under Medicare FFS is

³If a plan has a population with health expenditures that on average are the same as those for Medicare FFS, then the plan would have a risk score of one. If a plan has a population with projected health expenditures that on average are greater than or less than those for an average beneficiary in Medicare FFS, then the plan's risk score would be greater than or less than one, respectively.

calculated for each county—one county may have an equivalent inpatient cost-sharing percentage of 10 percent, while another county may have a percentage of 8 percent. For Part B services, however, the cost-sharing percentages are a national average, so the same percentages were applied to all counties. We divided each plan's estimated cost sharing and the Medicare-equivalent cost sharing by each plan's projected risk score to get estimated cost sharing for a beneficiary with average Medicare health spending. We reported the percentage of plans that had cost sharing higher than the estimated Medicare cost sharing for a given service category.

When we calculated the amount of reduced cost sharing, we used the total amounts reported in the bid pricing data. We included both rebates and additional premiums because this provided the accurate amount of cost-sharing reductions that MA plans projected their beneficiaries will receive. The amounts of the additional benefits and cost-sharing reductions in our analyses would be lower if we had restricted our analysis to rebates as the sole funding source.

To determine plans' out-of-pocket maximums, we examined the in-network out-of-pocket maximum and the combined out-of-pocket maximum (a maximum that applies to both in-network and out-of-network services) fields in the benefit package data. If the two fields were the same value, then we defined the out-of-pocket maximum as equal to that value. If one of the fields was blank, and the other field was a positive number, then we defined the out-of-pocket maximum as equal to the value of the field with the positive number. If both fields had a positive number, but they were not equal, then we defined the out-of-pocket maximum as equal to the value of the field with the lower value. We categorized a plan as having an out-of-pocket maximum even if the plan excluded certain categories of service from that maximum. We did not categorize a plan that had only a service-specific maximum as having an out-of-pocket maximum.

To determine the percentage of total revenue allocated to medical expenses and other expenses, we used the bid pricing data and calculated the projected values of medical expenses, non-medical expenses, and margin as a percentage of revenue for all plans and by plan type.⁴ We

⁴The bid pricing data exclude the additional revenue requirements for beneficiaries with end-stage renal disease from this calculation.

Appendix D: Scope and Methodology

reported the percentages of beneficiaries in plans that projected medical expenses less than 85 percent. We also analyzed the percentage of revenue projected to go to sales and marketing from the bid pricing data.

Appendix III: Plan Variation in Rebate Amounts

Rebate amounts, as well as the allocation of rebates, varied considerably from plan to plan. To provide a measure of this variation, we calculated rebate amounts and the amounts of additional benefits, reduced premiums, and reduced cost sharing at the 25th and 75th percentiles, weighted for enrollment. A percentile is the value below which a certain percentage of beneficiaries fall. For example, the value of the cost-sharing reduction at the 25th percentile was \$30.02 PMPM and at the 75th percentile was \$78.90 PMPM, meaning that at least 25 percent of beneficiaries were in plans that projected a cost-sharing reduction of \$30.02 PMPM or less, and at least 75 percent of beneficiaries were in plans that projected a cost-sharing reduction of \$78.90 PMPM or less. (See table 7.)

Table 7: Rebate Amount Allocated to Additional Benefits, Premium Reductions, and Cost-Sharing Reductions by Plan Type, 2007

Average	HMO Plans = 1,179 Beneficiaries = 3,747,587	PPPS Plans = 367 Beneficiaries = 1,361,686	PPO Plans = 306 Beneficiaries = 259,480	All plans ^a Plans = 1,874 Beneficiaries = 5,454,573
Rebate total				
25 th percentile	\$57.81	\$59.70	\$37.33	\$56.32
75 th percentile	119.19	63.36	69.83	109.55
Amount of rebate allocated to				
Additional benefits^b				
25 th percentile	4.14	0.00	3.56	2.75
75 th percentile	15.51	11.41	13.99	13.70
Part D premium reduction^c				
25 th percentile	0.21	0.00	0.00	0.00
75 th percentile	24.04	24.12	7.25	24.12
Part B premium reduction				
25 th percentile	0.00	0.00	0.00	0.00
75 th percentile	0.00	0.00	0.00	0.00
Cost-sharing reduction^d				
25 th percentile	42.89	38.02	26.79	39.02
75 th percentile	84.88	68.66	52.60	78.90

Source: GAO analysis of 2007 CMS Set Pricing Test data.

Notes: Values are weighted by August 2007 plan enrollment and are standardized to represent a beneficiary of average health status. Employee plans, Part B only plans, SPOs, regional PPOs, and plans with service areas that are exclusively outside of the 50 states and the District of Columbia were excluded from the analysis. There were 1,874 plans that received a rebate.

Appendix III: Plan Variation in Rebate Amounts

¹The "All plans" category includes HMOs, PFFS plans, PPOs, and PSOs. Results are not reported separately for PSOs because there were only 22 PSO plans and enrollment in those plans constituted 1 percent of total MA enrollment.

²The rebate amounts allocated toward cost sharing and additional benefits included some non-medical expenses, such as administrative costs and plan margins.

³Of 1,874 plans that received a rebate, 1,423 offered Part D benefits to their beneficiaries. Of those that offered Part D, 1,607 reduced Part D premiums.

Appendix IV: Plan Variation in the Out-of-Pocket Maximum

In 2007, about half of MA beneficiaries were in plans that had an out-of-pocket maximum, a dollar limit on a beneficiary's cost sharing. The out-of-pocket maximum varied from plan to plan. To provide a measure of this out-of-pocket maximum variation, we calculated the out-of-pocket maximum at the 25th and 75th percentiles, weighted for enrollment. A percentile is the value below which a certain percentage of beneficiaries fall. For example, the out-of-pocket maximum at the 25th percentile was \$2,750, and at the 75th percentile it was \$4,600, meaning that at least 25 percent of beneficiaries were in plans with an out-of-pocket maximum \$2,750 or less, and at least 75 percent of beneficiaries were in plans with an out-of-pocket maximum of \$4,600 or less. (See table 8.)

Table 8: Variation in Values of Out-of-Pocket Maximum by Plan Type, 2007

	Plan type			
	HMO Plans = 444 Beneficiaries = 1,436,148	PFFS Plans = 350 Beneficiaries = 1,987,383	PPO Plans = 219 Beneficiaries = 295,713	All plans ^a Plans = 1,016 Beneficiaries = 2,738,531
Value of out-of-pocket maximum				
Average	\$3,204	\$4,026	\$2,377	\$3,463
25 th percentile	2,750	3,000	1,900	2,750
75 th percentile	4,000	5,000	3,100	4,600

Source: GAO analysis of 2007 CMS Medicare Part C data.

Notes: Values are weighted by plan enrollment. If a plan had two out-of-pocket maximums—one for in-network services and one for combined in- and out-of-network services, then we used the lower value for this analysis. Determination of a plan's overall out-of-pocket maximum did not take into account whether a plan had a maximum for a specific category of service. Employer plans, Part D only plans, SNPs, regional PPOs, and plans with service areas that are exclusively outside of the 50 states and the District of Columbia were excluded from the analysis.

^aThe "All plans" category includes HMOs, PFFS plans, PPOs, and POSs. Results are not reported separately for POSs because there were only 22 POS plans and enrollment in these plans constituted 1 percent of total MA enrollment.

Appendix V: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Center for Medicare & Medicaid Services

Office of the Administrator
Washington, DC 20097

FEB - 1 2008

DATE:

TO: James C. Conterio
Director, Health Care
Department Accountability Office

FROM: Kerry W. Ryan 
Acting Administrator

SUBJECT: Department Accountability Office (GAO) Draft Report: MEDICARE ADVANTAGE: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs (GAO-08-238)

Thank you for the opportunity to review and comment on the GAO draft report referenced above. In this draft report, the GAO examined: (1) Medicare Advantage (MA) plans' projected rebate calculations; (2) additional benefits MA plans contractually covered and their costs; (3) MA plans' projected cost-sharing; and (4) MA plans' allocation of projected revenues and expenses.

General Comments

Inpatient Cost Sharing

The report finds that out-of-pocket costs for inpatient services are more than double for 36 percent of MA enrollees than in Fee-for-Service (FFS). We do not disagree with the findings; however, the report does not address a number of issues that mitigate the impact of the finding:

(1) **MA handling of cost-sharing versus scheduled FFS cost-sharing.** We believe that GAO did not take into consideration that an inpatient stay under FFS is not comprised of just the deductible amount for each hospitalization. It also contains a professional service charge which is billed to the beneficiary. As an example of the type of expenses incurred by a FFS beneficiary for a 90-day hospital stay, the average professional service co-pay under FFS alone is equal to \$5,280. MA enrollees do not receive a separate bill for professional services. The cost of these Part B services were not incorporated into the GAO analysis and therefore overstate the effect of inpatient cost-sharing on the possible MA enrollee cost in the draft report.

(2) **MA is more protective for longer hospitalizations than FFS.** The report also does not contemplate the FFS costs for a long hospitalization (i.e., more than 15 days) compared to a long hospitalization under MA. The Centers for Medicare & Medicaid Services (CMS) has data to show that MA plans have lower cost sharing for an inpatient stay than an FFS stay for longer stays. For example 91 percent of MA plans have a lower cost share than FFS for a 90-day stay.

Page 2 – James C. Conroy

and 85 percent of MA plans have a lower cost share than FFS for a 35-day stay. Figure 4 on Page 21 is misleading in that it only compares out-of-pocket costs for 33 days of hospitalization or less. Less healthy beneficiaries may have longer than 33-day hospitalizations in a year. We would recommend providing longer inpatient hospitalization information and a figure demonstrating it to give a more balanced perspective on inpatient hospitalizations.

3) The report does not address effective out-of-pocket limits for inpatient stays. Maximum out-of-pocket values in the plan benefit package (PBP) data are not the only way to specify the maximum amount an enrollee will pay for a specific benefit. For example, a plan showing no out-of-pocket maximum value in its PBP but having a \$200 per day capay for days 1 through 6 of inpatient stays has an effective maximum cost, but out-of-pocket cost of \$1,200 for inpatient stays regardless of the length of stay. In fact, most plans “may not” have out-of-pocket caps for inpatient stays or values far less than those for FFS. Our data show that, for the same population of plans GAO includes, 74 percent of enrollees in 2007 were in plans having an effective maximum out-of-pocket for inpatient stays of \$1,000 or less and nearly 100 percent of enrollees were in plans having an effective maximum out-of-pocket costs less than the FFS Medicare value.

4) Misrepresentation of data in text, table and figures on inpatient cost sharing.

- Footnote b to Table 4 states: “In some cases, MA plans include cost sharing for professional services, such as physician visits in, in the inpatient category.” We believe that because plans include professional services in the bundled inpatient cost sharing, the data in Table 4 is a misrepresentation of a true comparison between MA inpatient cost sharing and FFS inpatient cost sharing. That is, inpatient cost sharing for MA will naturally look higher than FFS in your table because of the inclusion of professional services under the inpatient services category for MA.
- Also, about 1/5 of Medicare FFS inpatient admissions fall within an existing benefit period resulting in no beneficiary liability for the Part A deductible. Also, FFS beneficiaries are required to pay cost sharing beginning on day 61 of an inpatient admission. Further, FFS beneficiaries are required to pay certain Part B cost sharing for care provided in inpatient facilities. Accordingly, the FFS representation in Figure 8 has an incorrect level and slope, and we suggest that the chart be modified accordingly, or removed from the report.

5) Part D drugs and out-of-pocket maximums and more than 1 million affected enrollees. We believe that the number and impact contained in this report is overstated. Part D drugs administered in a physician’s office would be included under an out-of-pocket cap because the bill for the Part D administration would be incurred as a physician office visit. The exclusion of Part D drugs from out-of-pocket maximums is for those drugs obtained from a pharmacy (as opposed to at the physician’s office). We believe that Part D drugs obtained at the pharmacy represents a subset of the 2007 plans with a Part B drug out-of-pocket maximum exclusion.

Page 3 – James C. Conrath

46 We believe that the report misstates the fact that the majority of MA benefit packages in 2001 are better and, on many occasions, less costly than FFS. Overall, MA benefit packages in 2001 are better than FFS. Some examples include:

- MA plans are not required to cap out-of-pocket expenses for enrollees; however, almost one-half (48 percent) of 2007 cap out-of-pocket expenses for enrollees, making them far more protective than an FFS beneficiary who has no cap on out-of-pocket costs.
- 12.8 percent of enrollees are in plans with a 71-day inpatient psychiatric stay cost less than that of FFS.
- 93.8 percent of enrollees are in plans with an out-of-pocket cost for annual rural visits (dilatant) less than that of FFS.
- 98.4 percent of enrollees have access to a plan with a maximum out-of-pocket value of \$3,350 or less that includes key specific benefit categories.
- 87.3 percent of the plans cover additional inpatient hospital days beyond the FFS allowed 90-day maximum.

To *the contrary*, the report fails to acknowledge that MA plans provide beneficiaries with a variety of choices in benefit structures other than original Medicare. Those choices allow beneficiaries to select a benefit structure that best suits their medical needs while taking their financial considerations into account. For example, some beneficiaries may prefer to pay lower cost-sharing for some Medicare benefits that they anticipate using during the year, and are willing to accept the risk of paying higher cost-sharing on other benefits should they need them.

We are also concerned that this report is unfairly skewed. To name a few that we believe should be addressed:

- a. The title is misleading and does not reflect the content of the report. GAO report titles should be neutral, or, at least, not misrepresent the contents of the report.
- b. On page 1 of the report, the discussion of the payment increases based on the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 fails to address the intention of Congress to expand access to MA plans to rural areas.
- c. The presentation of MA plans that offer cost sharing that is higher than Medicare FFS does not provide a similarly balanced presentation of examples of plans offering cost sharing lower than FFS. As such, the report relies on cost plan designs (high inpatient cost sharing) with outlier plan services (e.g., long inpatient lengths of stay) to make its point.

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

James C. Cosgrove, (202) 512-7114 or ccosgrove@gao.gov

Acknowledgments

Other contributors to this report include Christine Bradecold, Assistant Director; Jennie Agter; William Black; Alexander Dworkowitz; Gregory Gusto; Dan Lee; Hillary Loeffler; and Christina C. Serna.

GAO's Mission	The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.
Obtaining Copies of GAO Reports and Testimony	The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "E-mail Updates."
Order by Mail or Phone	The first copy of each printed report is free. Additional copies are \$2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to: U.S. Government Accountability Office 441 G Street NW, Room LM Washington, DC 20548 To order by Phone: Voice: (202) 512-6000 TDD: (202) 512-2537 Fax: (202) 512-6001
To Report Fraud, Waste, and Abuse in Federal Programs	Contact: Web site: www.gao.gov/fraudnet/fraudnet.htm E-mail: fraudnet@gao.gov Automated answering system: (800) 424-5454 or (202) 512-7470
Congressional Relations	Ralph Dawn, Managing Director, dawnr@gao.gov , (202) 512-4400 U.S. Government Accountability Office, 441 G Street NW, Room T125 Washington, DC 20548
Public Affairs	Chuck Young, Managing Director, younge1@gao.gov , (202) 512-4800 U.S. Government Accountability Office, 441 G Street NW, Room T149 Washington, DC 20548

Chairman STARK. Thank you. Is it your feeling, Mr. Cosgrove, that if we required data from the plans, obviously retroactively, as to what they actually provided—and I guess I would like to make this distinction, Mr. Weems and Mr. Cosgrove—a benefit offered is a different cat than a benefit used.

In other words, take a look at me and you could offer me a lifetime membership in a weightlifting club, and as valuable as that might be to my young, vigorous ranking member, it would be absolutely useless to me. And so while it has a value if I used it or if

I could sell it to somebody, so if you offer—I was looking at the dental benefit, for example. Four bucks a month, that is less than \$50 a year. Now, I don't think you can get your teeth cleaned for \$50 any place. As I recall, it is maybe \$100 and change, as I think.

So, I mean, I think that if we had some figures as to what was actually spent and used by our beneficiaries, we would have a better ability to assess the value of these plans. Is that—

Mr. COSGROVE. Absolutely. We have no information on utilization. I want to point out that the dental benefit, the \$4 per member per month, was on average the most expensive additional benefit the plans offered. And \$1 of that \$4 is actually paid by beneficiaries through additional premiums.

Chairman STARK. Also, we skipped over here. But according to your full report, a third of the private fee-for-service plans—and I am sure our guests will learn that there are kind of two plans, I think, or two types of plans—charge more for home healthcare than stand-alone fee-for-service Medicare, and if they offer an out-of-pocket cap, they often exclude things like mental health, home healthcare, the most valued for very sick people and probably the most expensive for them to provide.

Is that a fair assessment of—

Mr. COSGROVE. Overall, roughly half of beneficiaries are in plans that have a cap, but half of those are in plans that have a cap that excludes something. And home health is frequently one of the services that are excluded, yes.

Chairman STARK. And we are talking generally across the spectrum about a medical loss ratio of 85 percent, some perhaps a little higher, a third of the plans or 30 percent of the plans lower.

Mr. COSGROVE. That is correct.

Chairman STARK. And just for the record, what that means is that 85 percent of what the plans take in in premiums or subsidies or government payments, whatever, for every dollar, they spend 85 cents on medical care and the other 15 cents can be most anything.

Mr. COSGROVE. Well, the other 15 cents is going to administrative expenses and profit.

Chairman STARK. And if you compare that with Medicare, our medical loss ratio there is north of 95 percent, probably 97, 98 percent. Is that fair, Mr. Weems?

Mr. WEEMS. According to the trustees' report, it is approximately 98 percent.

Chairman STARK. So what we are saying is for every buck the taxpayers and the beneficiaries pay into Medicare, they are getting 97 or 98 cents' worth of medical care. And I think that is important to compare.

And I know, Mr. Weems, you have suggested that in the services offered—and again, I don't want to beat this dead horse—but when you say that two-thirds of the plans have coverage for eyeglasses, you don't mean that they get a pair of eyeglasses every year?

Mr. WEEMS. No.

Chairman STARK. All right. And they are often a limited dollar amount?

Mr. WEEMS. Typically.

Chairman STARK. And so that for any of my colleagues who, as I do, have Blue Cross, and they give you a list of places where you

think you can get eyeglasses for 50 bucks, guess again. I mean, maybe \$500, unless you go to Wal-Mart or Costco. But we don't have, I think—and I think we will hear from witnesses later—either defined benefits and/or marketing restrictions that would prevail in most States.

We have pretty defined benefits under the old Medigap rules. I mean, what, are there 11 plans?

Mr. WEEMS. Right.

Chairman STARK. And when we wrote that bill, I think we had pretty much agreement among all the insurers who were writing Medigap at the time, including AARP and whoever else was in the business, that with those 11 plans, that gave them enough leeway to provide a variety of coverage for people to choose from.

Why wouldn't something similar to that be useful to the beneficiaries in Medicare Advantage? Let's say that we said, look. If you have got how many thousand plans here, let's design a set of benefits within which, these parameters, they could operate and compete, come back to you or to us for additional benefits if necessary. But why wouldn't that simplify your lives for keeping track of it, ours for understanding what the beneficiaries are entitled to.

Do you have an objection to that, Mr. Weems?

Mr. WEEMS. Mr. Chairman, at its heart, the Medicare Advantage program is about choice. And restrictions on the benefits would limit those choices. And I think we should be in a position of giving our beneficiaries a large number of choices. One of the things that we have done is to move to make sure that those choices are more understandable and presented to beneficiaries in a more standardized fashion.

Chairman STARK. But you don't think they should be limited in number?

Mr. WEEMS. No, sir.

Chairman STARK. Well, then, in Part D, you would suggest that anybody signing up for a Part D drug plan should be able to buy any drug they want?

Mr. WEEMS. Well, not any drug. We want to make sure that they are FDA approved.

Chairman STARK. I will spot you that one. What is next?

Mr. WEEMS. Well, and then we allow plans to provide choices through various formularies.

Chairman STARK. But you allow them to limit my choice, don't you?

Mr. WEEMS. The same way that Medicare Advantage plans allow a range of choices through different benefit arrangements. Yes, sir.

Chairman STARK. Okay. Mr. Camp?

Mr. CAMP. Thank you.

Mr. Cosgrove, let me first begin by saying I appreciate the GAO staff briefing the minority staff earlier in the week on this report. I am disappointed we couldn't get the full report before today's hearing, yet apparently the New York Times did not have this problem as there is a story in today's paper quoting from the report. So they had things that the minority staff didn't have. If we are going to have a meaningful discussion, I think we do need full information.

Now, just let me move on to the thrust of the report as I understand it in this short time frame. I am concerned that your report isn't an actual representation of beneficiaries enrolled in Medicare Advantage plans but instead, again, this hypothetical scenario for beneficiaries using a single type of service for a small subset of plans.

So let me ask you: In your testimony, you included a chart that showed how Medicare beneficiaries could pay more for inpatient services. Is it true that this just reflects one plan out of over 2,000?

Mr. COSGROVE. No. It is a representative plan out of 80 plans that we found.

Mr. CAMP. I believe it is a representative of one plan out of over 2,000 plans beneficiaries have choices of. Let me ask you again: Is it true that 84 percent of beneficiaries are enrolled in plans where they could pay less cost-sharing for input services than in traditional fee-for-service?

Mr. COSGROVE. Well, as we point out in the report—

Mr. CAMP. I believe the answer is "Yes" to that, and I guess I would prefer just a simple answer there. I am correct, am I not?

Mr. COSGROVE. Yes.

Mr. CAMP. Is it also true that over half a million beneficiaries are enrolled in plans that charge no cost-sharing for inpatient hospital stays?

Mr. COSGROVE. Yes. That is in our report.

Mr. CAMP. I think it is important to understand that many beneficiaries who are buying insurance are buying protection against catastrophic events, even if they don't use it. And from what I can understand, the services that you have chosen to look at are used less often. And, frankly, services such as physician office visits, which are used more often, are less likely to have a higher copay.

So I think we have to look at the kinds of comparisons that are being made. And, frankly, your report looks at inpatient hospital and home health and ignores physician office visits, which 97 percent of beneficiaries experience, 8.5 percent experiencing home health and 25 percent experiencing inpatient hospital.

You know, it is my view that this report ignores reality. And I think if we are going to have a meaningful discussion—and I appreciate, Mr. Weems, your comments that you are going to get some actual data to us so that we can really have a meaningful discussion about this. So thank you for that. Thank you for your testimony as well.

So I guess I think it is important that we get a report that is real, that we have an opportunity to review so that we can have a meaningful discussion. I think this really is a fake report with fake conclusions, and we are having this fake hearing about it so we can all run to the media and make certain pronouncements.

I think healthcare is too important. I think our seniors are too important. I think the choices that they want to make are too important to conduct the people's business in this way.

So again, I am going to send a letter to the Comptroller General. I look forward to his response as soon as possible. Thank you, Mr. Chairman.

Chairman STARK. Well, you are welcome. I am sure that there will be others here who don't like the report, and I will reserve my comment until a second round and ask Mr. Thompson if he would like to inquire.

Mr. THOMPSON. Thank you, Mr. Chairman.

Mr. Cosgrove, we have heard in testimony before this committee in the past, and we heard it again today, that Medicare Advantage plans, especially private fee-for-service plans, are rapidly increasing in enrollment.

And your testimony notes that the Medicare Advantage plans were originally envisioned as a potential source of savings. Is that correct?

Mr. COSGROVE. That is correct. What was once called the risk program started in the 1980s, yes.

Mr. THOMPSON. Are they currently achieving savings for today's Medicare program?

Mr. COSGROVE. No, absolutely not. According to the MedPAC analysis, the average plan bid for simply providing A and B services is 101 percent of fee-for-service. And on top of that, plans get rebates.

Mr. THOMPSON. I would like to talk about something that hadn't been brought up yet, and that is the impact that these plans are having, and if we don't do some sort of reform to the Medicare Advantage plans, will continue to have on Medicare's trust fund solvency.

Can you speak to that at all?

Mr. COSGROVE. As I mentioned in my statement, in 2006, for example, we paid an additional \$7.1 billion extra to Medicare Advantage plans that would not have been paid if those beneficiaries had been in fee-for-service. It is true that beneficiaries in those plans did receive lower cost-sharing and additional benefits. But there is not a free lunch. That came out of the \$7 billion.

Mr. THOMPSON. And it is my understanding that the Medicare Advantage overpayments and rebates, had it not been for those, the Medicare trigger never would have been pulled. Can you comment on that at all?

Mr. COSGROVE. I have heard that. I haven't looked at the numbers. According to the Medicare actuary, it certainly has reduced the life of the HI trust fund. And it certainly has contributed to higher Part B for all beneficiaries.

Mr. THOMPSON. And your report also found that plans are allocating 20 percent of their rebates, or \$17 per month, on reducing premiums. However, you note that 41 percent of the beneficiaries are charged an additional premium for the privilege of participating in a Medicare Advantage plan, and that the additional premium averages about \$58 per month.

So at the end of the day, are the beneficiaries who are charged an additional premium actually seeing any savings on their premium cost?

Mr. COSGROVE. Well, they are seeing—the average beneficiary is seeing savings overall, but not on the premium cost, no.

Mr. THOMPSON. And how about in comparison to traditional Medicare?

Mr. COSGROVE. I am sorry. The question is?

Mr. THOMPSON. The savings, the cost savings over beneficiaries in traditional Medicare?

Mr. COSGROVE. Well, again, it depends on whether you are talking about the average beneficiary or some beneficiaries. The average beneficiary would see, overall, some cost savings. But there are beneficiaries in plans who could see higher expenses.

Mr. THOMPSON. Mr. Weems?

Mr. WEEMS. Good morning, sir.

Mr. THOMPSON. I am perplexed that the budget, the administration budget, paid a lot of attention to Medicare spending and solvency, specifically in the areas where they tried to strengthen Medicare such as cutting physician rates by over 10 percent or cutting hospital payments billions of dollars, so severely, I might add, that in California our hospitals alone would see a loss of over \$800 million in 2009. And yet there is no mention of any payment reform for Medicare Advantage plans.

GAO stated that these plans achieve no savings. CBO has stated that reforming the Medicare Advantage payment rates would improve trust fund solvency. And MedPAC has stated that there is no policy-based merit for these overpayments.

Why do you think these plans deserve such special treatment when it is clear that they don't yield any special results? And if you guys aren't listening to the GAO and the CBO and MedPAC, which experts are you listening to when you develop your policy for the Medicare Advantage policies?

Mr. WEEMS. Thank you, Congressman. Medicare Advantage at its heart is about choice. You note the growth in private fee-for-service. That growth is in rural areas, where the kinds of services and benefits that Medicare Advantage offers has not been available.

As for our budget, our budget protects those kinds of choices but goes directly to the kinds of solvency issues that you mention. If our budget were enacted, the solvency of the Part A trust fund would be extended by ten years.

Mr. THOMPSON. I would like to see your budget come to a vote of this full committee and to a vote of the full House because I don't think there are three votes for it. You cannot tell me that if we cut by over 10 percent physician rates and decimate funding for hospitals, and those are hospitals that are also in rural areas, that somehow that is good for the people who need healthcare in not only rural areas but urban areas as well.

And to the question of who you listen to, who you get your information from in developing these policies?

Mr. WEEMS. Congressman, we get information from a variety of sources, including the GAO, the Congressional Budget Office, outside groups.

Mr. THOMPSON. And MedPAC?

Mr. WEEMS. And MedPAC.

Mr. THOMPSON. But they have all said contrary to what your policies are proposing.

Mr. WEEMS. Those are financial analyses. The Congress, when it enacted this bill, made a policy choice about choice. And that at its heart is what Medicare Advantage is. It is about giving beneficiaries choices.

Mr. THOMPSON. Thank you.

Chairman STARK. If the gentleman would yield, I believe, Mr. Weems, your own actuary said we are paying too much for Medicare advantage.

Mr. WEEMS. Our own actuary would say that——

Chairman STARK. He may not phrase it that way.

Mr. WEEMS. He would say that Medicare Advantage is paying above the fee-for-service rate. Yes, sir.

Chairman STARK. Well done. You are not going to fire him.

Mr. Becerra, would you like to inquire?

Mr. BECERRA. Thank you, Mr. Chairman. And thank you for coming to testify today.

Let me see if I can ask Mr. Cosgrove to make something clear to me. The gentleman from Michigan, Mr. Camp, took umbrage to the fact that your report was based on projections and did not in one instance talk about the reality for one particular individual who receives his or her care through the Medicare program's Medicare Advantage system.

And just to be clear, Medicare Advantage is an HMO-type setting where, through an insurance program, through an insurance company, a senior receives his or her care versus the senior receiving traditional Medicare, which is where the senior can go to any doctor or any hospital to receive the care because he or she is a Medicare beneficiary and can go anywhere he or she likes. But if you go to the insurance company and that insurance company system, you have to stay within that system, and you accept that package that that system offers you.

But again, Mr. Camp took offense that your report was based totally on hypotheticals, on projections.

Mr. COSGROVE. Yes.

Mr. BECERRA. My understanding is you had no choice but to base it on hypotheticals and on projections because the law doesn't require CMS to talk about real people. And so therefore, your analysis has to be based on what you get from CMS. Is that correct?

Mr. COSGROVE. That is absolutely correct. Plans are not required to provide any data on what they actually spent or the benefits they actually provided. The only data that we have available are the data the plans submit annually, and that is in their bid proposals and their plan benefit packages.

Mr. BECERRA. And so, Mr. Cosgrove, your projections and analysis of these hypothetical patients under these Medicare Advantage plans that Mr. Camp took offense to are the actual projections or based on the actual projections provided by the plans themselves to CMS?

Mr. COSGROVE. Yes. That is true.

Mr. BECERRA. So our difficulty—and I agree with Mr. Camp, we should be talking about real people. Your problem is when the Congress in early 2000, or 2002 or so, passed this law on Medicare Advantage under the then-Republican-controlled Congress, it did not require CMS to collect data on real people. In fact, CMS has no authority under statute to collect information on real people under the Medicare Advantage plans. Is that correct?

Mr. COSGROVE. That is correct. And that contrasts with the situation in Medicaid, where many States contract with managed care

plans and require those plans to provide data so that States can know whether their Medicaid beneficiaries are receiving preventive care and other services.

Mr. BECERRA. So I think all of us probably on this dais would agree with Mr. Camp that we should be talking about real people, which would require that the plans do what other medical programs that get government subsidies do, and that is to report on real people, what their outcomes are. And I think it will be fair to ask for that and then base some of our judgment on that.

A few years ago—actually, a number of years ago—we would constantly hear stories about the 3- or 4- or \$500 toilet seat that the Department of Defense was buying for this or that plane or facility, how we are paying tens of dollars for a screw. And we just found that things weren't being done well, and lots of waste in the Department of Defense.

We are being told by the plans that they will do certain things with the money we are giving them, and including the rebate, which is above and beyond what a doctor or hospital would receive under traditional Medicare.

Mr. COSGROVE. Right.

Mr. BECERRA. But we have no guarantee, as I think Mr. Camp pointed out, what in fact real people are getting from these plans. And so while it may not be the same as a \$500 toilet seat, in many ways we can't determine if we are getting a \$500 toilet seat or not out of some of these plans, can we?

Mr. COSGROVE. That is absolutely correct. There is no way to determine that. We would certainly welcome the request from Mr. Camp, and we would welcome the ability to get data from plans.

Mr. BECERRA. And I think it is important for us to get that information because many of us are in some of these health plans, or have family or friends who are in these health plans. My parents are in a Medicare Advantage plan, in Kaiser—Mr. Stark mentioned Kaiser—in Sacramento, California. They have been in Kaiser. They enjoy having Kaiser as their provider. And so there are a lot of plans that are doing some great work.

And so I think what we want to do is get the facts so that we don't disparage the good folks who are providing good services. And that way we could distinguish between those that are providing the best of services.

My final question is this: I believe, Mr. Weems, you mentioned at the end, right before I started my questioning, that in fact the actuary for CMS has said that Medicare Advantage plans are receiving a greater reimbursement amount or dollar amount than are traditional fee-for-service providers.

Mr. WEEMS. That is correct.

Mr. BECERRA. And I believe, Mr. Cosgrove, you said that total \$59 billion more is going to Medicare Advantage than would go for the same services under a traditional Medicare service program.

Mr. COSGROVE. No. That was total spending in 2006. The additional spending amounted to \$7.1 billion in one year.

Mr. BECERRA. Okay, \$7.1 billion. And so we are talking real money. Whatever the amount is, we are talking real money. And those are billions of dollars that we spent, taxpayers spent, to provide Medicare services to seniors. Not really sure how it was spent.

In some cases we think it was spent well. Other cases we are wondering.

But given that we are in this crisis and everyone is talking about how the sky is falling for healthcare, and Medicare in particular, I think we do have to get the real numbers. So I think, Mr. Weems, we are looking forward to receiving that information. And I think Mr. Camp's request is legitimate, and I hope we all join in requesting that information so that we can base our aim on the facts.

So I thank the gentlemen, and the chairman for the time.

Chairman STARK. And before I recognize Mr. Pomeroy, I would like to—Mr. Camp is carrying the whole other side of the dais here, and I would like to give it to him for a few minutes.

Mr. CAMP. I certainly appreciate it, Mr. Chair. I just want to comment.

I didn't ask to be yielded to during your time, Mr. Becerra. But it is part of it that it is not just real people, but it is also the problem that it is only inpatient and home health. And those services that are used more often, which are not included in this report, have a higher cost-sharing.

So I think it is not just the people. It is the focus of the report. I would also like to see them include physician office visits and other portions, not just inpatient and home health.

So thank you, Mr. Chairman.

Chairman STARK. Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. Yes, Mr. Chairman. Thank you.

I have the greatest respect for the administrator. He has come to North Dakota. He has helped us with the hospital problem. A career man, ultimately appropriately on merit advanced to the No. 1 slot. And I am very pleased—truly, I am very pleased with his leadership. This is a no-nonsense, get-it-done guy. And we know that representing the administration, he has to defend Medicare Advantage.

What I want to focus on is what we are getting for the extra money we are paying. So, Mr. Administrator, you don't contest the \$7 billion in extra payment as opposed to if we had run those same benefits through Medicare. We paid \$7 billion extra to have the insurance companies involved.

Do you agree with GAO's comment on that?

Mr. WEEMS. That there are additional costs associated with the additional benefits and additional choice; that, right now, Medicare Advantage plans are above the fee-for-service rate.

Mr. POMEROY. And because of the variety on the plans that are not fee-for-service, let's just talk about Medicare Advantage Private fee-for-service. It is generally believed that we are paying somewhere in the neighborhood of 12 to 17 percent more per dollar of benefit administered in order to have the private entity make that payment. Do you contest that?

Mr. WEEMS. It is not just the private entity make that payment. It is also the insurance value of the product that is being purchased by the individual, by Medicare, at that point. It is not just simply an administrative processing.

For instance, a private fee-for-service plan offers in some cases, for instance, a known co-payment for a doctor's visit. So a regular doctor's visit will, say, cost \$20, not 20 percent, or \$10, or \$5. So

the additional benefits may come in the certainty of cost-sharing, the same way many of us have that certainty in our own private insurance that we have rather than a percentage, which would now be the case for——

Mr. POMEROY. Although Medigap insurance has existed for decades that covers the unknown of the other coverages. And people can choose that if they care to. But as a system, we are paying 17 percent more to have the private insurance companies administer that benefit, and the rationale is, it is about choice. Is that basically your position?

Mr. WEEMS. Again, with respect I take issue with the “administer the benefit.” They offer additional benefits also. But yes, it is about choice. It is about offering these type products in areas which, before, they were not able to be offered.

Mr. POMEROY. I just take such issue with the administration’s assessment of priorities within the Medicare program, as reflected in their budget. I have got a whole page here of provider cuts, deep and painful provider cuts. The total in North Dakota would be devastating to the healthcare delivery system sustained across our rural reaches.

You close a rural hospital, you have taken away choice. You drive physicians out of accepting Medicare because they are reimbursed so far below costs they just don’t want to do that any more, and we are really believing we are about on the edge on that with some of our providers, you remove choice.

So in my opinion, you really take a meat axe to provider payments. I agree with my colleague Mike Thompson when he says there wouldn’t be any support for this on either side of the aisle because of the fear of that.

But on the other hand, you don’t take anything out of the overpayment to insurance companies that you acknowledge runs 12 to 17 percent. GAO tells us in one year we spent \$7 billion just to the insurers. If Medicare administers the benefit, we are \$7 billion better off in one year, \$35 billion over five at that rate. And the five-year figure actually is going to be much larger than that because of the marketing growth of Medicare plans.

Mr. WEEMS. Absolutely.

Mr. POMEROY. And I want to focus on that growth in my final comments. We have been exchanging correspondence trying to get a handle on the consumer protection capability within CMS. You are aware, of course, that this choice that you defend includes insurance agents making cold calls on the homes of senior citizens. Is that correct?

Mr. WEEMS. Yes.

Mr. POMEROY. There are not too many people I represent that choose to have that kind of visit. They would just as soon choose not to have that kind of visit.

Mr. WEEMS. Congressman——

Mr. POMEROY. But what worries me most about it is you don’t have much ability to oversee it, and you keep State regulators out of the picture.

Do you see a resolution there? How are we going to get more consumer protection for the people that are getting the cold calls from

the insurance companies paid 17 percent more for what they are doing than what Medicare does?

Mr. WEEMS. Thank you, and this is an important issue. No beneficiary should be deceived into accepting one of these products. And CMS has taken a number of steps, and have a number of steps underway, to prevent this.

First of all, beginning in September, we built a rather substantial surveillance system. And as you may know and others may know, we spend a lot of time and effort doing secret shopping and actually sitting in the marketing campaigns. I sat in on them in rural areas and in urban areas with a baseball cap on. They didn't know who I was. And immediately after those marketing campaigns, if there was a violation, we fed that right back to the plan. In some cases sanctioned them. And we saw a steady reduction in the amount of complaints.

We are not done yet. We have some additional actions that we are going to take in the very near future that deal with exactly the same kinds of things that you are concerned about: how an insurance company makes contact with a beneficiary, what their commission structure looks like, and then also clarifying some of our civil and monetary penalties.

Mr. POMEROY. I will just say—because I know my time is up—I mean, I used to do this for a living. I was an insurance commissioner. I wrote the Medicare standards that are now in place through the States as we enforce Medigap sales.

To me, what you are describing is very kind of happenstance. It is not a comprehensive regulatory system. The protections that you just described are available in State insurance departments and in State law, and I believe this administration ought to advance—I mean, for one thing, we try to get you more resources, the President vetoes the bill.

So you don't have enough resources internally. I believe you need to work with State insurance departments. And I would like to see more from CMS in terms of working arrangements there.

My time is expired, Mr. Chairman. Thank you.

Chairman STARK. Thank you.

Mr. CAMP. Thank you, Mr. Chairman. I have heard of being in the minority before, but this is—

Chairman STARK. Kind of a lonely day. [Laughter.]

Mr. CAMP. So thank you. Mr. Weems, I just wanted to say that I have heard some reports about some of the unacceptable behavior by agents and brokers who are selling some types of Medicare Advantage plans, and I think there is bipartisan agreement these activities need to be stopped.

What are you and CMS doing or going to do to stop this and protect beneficiaries from these kinds of individuals and plans?

Mr. WEEMS. Well, beginning in September, as I said, we built a rather substantial surveillance system, which included not only the secret shopper program but also a system of calling beneficiaries. Did you know you signed up for a plan? Do you know exactly what you signed up for? To ensure the beneficiaries understand the choices that they are making.

We also made it very, very clear to insurance companies that we are not going to tolerate this kind of abuse. In fact, one company,

we suspended. We had them suspend enrollment and marketing for the entire period of enrollment and marketing because there were systematic errors in the way that they were marketing the product, and it was completely unacceptable.

And there are still additional steps that we are going to take in the areas of the way that the commission structure works—beneficiaries should not be churned year to year; in the way that the insurance companies come into contact with the beneficiary; and then lastly, clarifying our own ability to level civil and monetary penalties.

Mr. CAMP. Also, if you could comment. Thank you for that answer. By purchasing a Medicare Advantage plan with a cap on cost-sharing, can beneficiaries protect themselves against catastrophic costs? And isn't that what insurance is about, is protecting yourself against something that you think might happen but may not necessarily happen?

Mr. WEEMS. Absolutely. And in fact, that is what this chart demonstrates, is that beneficiaries can make choices about where they would like to protect themselves. Even at the very, very long stays that we have on here, you ask yourself, well, what is the probability of that? What would cause that?

Well, our experts say that yes, there are some of those very long stays, and the things that cause them are substantial comorbidities. You are a very, very ill individual. But even being very, very ill, using a Medicare Advantage program, you can protect yourself from some very substantial out-of-pocket costs.

Mr. CAMP. Well, and I think nearly half of Medicare Advantage beneficiaries are in plans that cap their out-of-pocket costs. And is that something that is available in traditional Medicare, the ability to cap catastrophic healthcare costs?

Mr. WEEMS. No. No, it is not available in traditional Medicare.

Mr. CAMP. All right. Thank you. Thank you very much for your indulgence, Mr. Chairman. I appreciate it.

Chairman STARK. Mr. Kind, would you like to inquire?

Mr. KIND. Thank you, Mr. Chairman. And I want to thank the witnesses for your testimony today.

This is just an incredibly important issue back home. And Mr. Weems, I know you cited La Crosse, Wisconsin, which is in the heart of my congressional district in western Wisconsin, to make a point on—

Mr. WEEMS. A lovely city.

Mr. KIND. Right. I agree—to make a point on some of the regional differences in payments. And you compared it with Dade County, Florida.

But when you talk to the providers in western Wisconsin, they are always extremely frustrated that they are receiving, in their view, a lower reimbursement rate. And part of that is based on the efficiency and lower utilization that is taking place there. Yet study after study after study shows high quality of outcomes in the care that seniors are receiving under traditional fee-for-service.

And so I am not quite sure the regional differentiation that you are making in your testimony really applies all that well. It seems to be you are saying, listen. You got to look at the regional price

differences in order to explain the overpayments for MA plans today, and you use La Crosse as an example.

And in order to entice private plans to come into that area, in essence you have to bribe them above what the fee-for-service providers are getting in reimbursements. And I am not sure that is a real accurate apple-to-apple comparison to make under the circumstances.

My question is, and maybe Mr. Cosgrove, since you are the one releasing the study today, is what has been frustrating with the MA plans is the lack of hard data that we have access to. Is there any way that you can get your hands on quality of outcomes or performance base with what the MA plans are providing with seniors today?

*Mr. COSGROVE. There is relatively little information available on that. Certainly, under Medicare Advantage, plans do have to submit some things. And I think Mr. Weems mentioned it in his testimony in terms of satisfaction surveys and a health outcome survey to cover Part C of beneficiaries. Those surveys tend to measure very narrow things and not basic quality.

Mr. KIND. What about utilization data? Can we get any information at all from the myriad of MA plans out there on what utilization is taking place?

Mr. COSGROVE. I am sure MA plans have it. As you know, the plans that serve rural areas tend to be the private fee-for-service plans. These plans pay claims just like the traditional program does, and so they certainly would have the data. They just don't have to submit any of that.

Mr. KIND. And that is the rub, isn't it? I mean, that is really the crux of the problem here, is that they don't submit it. And yet CMS—and I think, Mr. Weems, you are saying in your testimony that in 2008, MA plans will offer, on average, over \$1100 in additional annual value to seniors that they cannot get under fee-for-service in the form of cost savings and added benefits.

Mr. WEEMS. Correct.

Mr. KIND. But if we can't get utilization data, if we don't know what type of services are being provided, how can you define value? How can you make that claim that there is \$1100 of additional value if we are not getting the basic data that we need in order to calculate the costs?

Mr. WEEMS. Well, Congressman, we are not completely blind to the utilization. It is in the bid tools. We do audit plans. We do have some sense of this. Nonetheless, I made a commitment today to the chairman to provide utilization information on the extra benefits, and to do that in an expedited way. And we will have a discussion about the facts.

Mr. KIND. That would be helpful. But I was astounded to hear your response to Mr. Thompson's earlier question when he was asking, what is CMS basing their defense and justification of these MA plans if you are going to choose to ignore GAO information, choose to ignore CBO information, choose to ignore MedPAC information, and your response was, well, it is all about choice.

That is a philosophy, but it is not based on hard data. And that is really what I think we are scrabbling to get our hands on right now, is these reporting requirements that should be in place so we

can go into these plans and find out what is being offered. What are the true cost savings, if any, to the customers? What is the value that they are receiving? The utilization that is taking place? And ultimately, I believe that we have got to move to an outcomes-based type of reimbursement system as quickly as possible so we are rewarding the outcomes, the quality of services being provided, and also the efficiency in which it is being provided.

And we are not getting that from the MA plans. Choice is great in a theoretical world. But when you have got a 70-year-old senior having to compare over 70 different plans in the State of Wisconsin that are continually shifting on them, whether it is copays or premiums, they are not the ones wrapping their arms about this whole choice philosophy. It is incredibly complicated. They are subject to marketing tactics that are unfair and it is taking advantage to them. And we need to tighten this up.

And it is also astounding to me that we have an administration willing to take a whack in their proposed budget with the providers across the country, and they don't look for one dollar of savings with these MA plans in the budget that was just sent up.

And Mr. Camp, I congratulate you for at least sitting here during this hearing. Where is the rest of the dais on your side? We are having, I think, a very important hearing on the state of MA plans, and yet there is no one on the Republican side other than yourself showing up to question the validity of it and whether the taxpayers are getting our dollars' worth through these plans.

And yet over \$170 billion of proposed cuts with healthcare providers—well, and I know he is campaigning hard—

Chairman STARK. One of them is running for the Senate in Wisconsin. You had better watch your step.

Mr. KIND. That is right. That is right. But I am only reflecting the frustration that I am hearing back home from the providers, from the seniors, those who are in the plans right now, and for us as policy-makers. And we are trying to make some policy determinations, and we lack the hard data that I think is necessary. So hopefully, with CMS's cooperation, we are going to be able to do a better job in the future.

Thank you, Mr. Chair.

Chairman STARK. I would like to recognize Mr. Emanuel. And if I could get our witnesses, we will have a couple of votes at about 11:15, and we will come back after those votes and allow the other members to inquire, if I can impose—presume on the witnesses to stick around for a few minutes while we vote.

Mr. Emanuel?

Mr. EMANUEL. I will try to be quick so maybe one of our other colleagues can get in before the votes are called.

I didn't expect you guys or anybody in the audience to see this, but the other day we had a debate among four Democrats and four Republicans over at George Washington University. And the congressman, Mr. Chairman, that you referred to from Wisconsin did acknowledge at the debate that he would take seriously and look—I think I am quoting him accurately; Paul said this, in fact—that he would look seriously at taking—that we shouldn't be 125 percent of fee-for-service as long as it didn't go into expanding coverage but dealt with the short fan of Medicare.

And when you get out of here and get out of posturing, he was honest about, you shouldn't be paying 120 percent. I mean, there is a reason this is called Medicare Advantage. It is a real advantage for the HMOs. There is just no doubt about it.

And this is a ideology trumping good judgment. Everybody always tells us government should do what business does. So here you got a case where you could save on money, but we are supposed to pay 120 percent. And I happen to have been there in the 1990s in the White House when the HMOs said they could deliver it for 95 percent of fee-for-service because they could do a better job of managing costs. So we are getting the same service now for 120 percent of fee-for-service.

There were some mistakes made in the 1990s, no doubt. But the notion that we are going to try to figure out how to deal with the trust fund, but something everybody independent analyzed says that could save \$50 billion over five years, \$150 billion over ten years, that is off the table, you are never going to get an honest discussion of everybody some skin in the game and putting something on the table.

You cannot have a serious discussion about Medicare's trust fund if the elephant in the room is not going to be discussed. And it is not the only elephant; we have got to look honestly at how we pay fee-for-service, whether there should be more flexibility. Some of the things the administration is pointing to are worth looking at. They are not going to be wholesale thrown out.

But the notion that this big item that you are overpaying for can't be looked at on the start gate means that you are never going to have a serious discussion and it is just going to be political. And at some point, ideology cannot trump good judgment. It just can't.

And if you did it all on HMO, Peter Orszag and others have acknowledged it would add three years to the trust fund. Three years. That is something that has to carry the whole burden here. But the notion that you would start off by saying, this can't be part of any solution, is ridiculous. It doesn't hold up. And people know it.

And that means every other good recommendation from the administration won't be considered. You have tainted it because you basically have said ideology and politics and partisanship trump getting a good judgment and a good result. And that is unfortunate for all the other good decisions you have made in some of the recommendations because they won't get a fair hearing. You have hurt yourself that way.

Second is, as Orszag testified in this committee the other day, we don't know what is in these plans and whether we are getting our money's worth. It is just like a blank check, something my kids would like to have. We wouldn't do that.

And you can't keep treating taxpayers as dumb money. You can't ask them to pay 120 percent for what you can get for 100 percent. You know, I spent a short time on Wall Street, and when people would make investments like that, you would call them dumb money.

So my recommendation is: Let's everybody put their cards on the table. There are good recommendations in the administration's proposal that are worth looking at. But if you start off by saying, we

won't look at this and that is an absolute, that means every other judgment you have made won't get a fair hearing, and you have hurt the cause of trying to look at what does it take to deal with the Medicare trust fund insolvency.

Thank you, Mr. Chairman. I hope I have left some time for my colleagues.

Chairman STARK. Ms. Schwartz, would you like to inquire?

Ms. SCHWARTZ. Yes. Thank you, Mr. Chairman. I really appreciate your courtesy in allowing me to ask a question or two.

And I appreciate following up on my colleagues. I think they have made it very clear, and I agree with them, that we are taxpayers, and actually 80 percent of beneficiaries under Medicare are paying more in order to give 20 percent of Medicare beneficiaries choice. You made that very clear.

The issue is we don't really know that they are getting more services. You can't tell us that. You can't really tell us whether they are actually having any improved outcomes. We have no idea. You are going to try and get us that data; that would be useful.

But the point was made that maybe—and Mr. Camp said this—that maybe we really haven't looked at real people here, that maybe real people are getting benefits and we just don't know it, but they are getting some additional benefits. They are happier because they have choice. I think when we talk about healthcare, we ought to make sure that they are healthier also.

But I want to talk about a particular experience in southeastern Pennsylvania in my district. One of the things that we have seen in the last year is really an incredible growth in the Medicare Advantage Private fee-for-service. That has been the strongest growing effort. I know the discussion was it was supposed to really be in rural areas; I don't represent a rural area. It is an urban/suburban area. We have seen an increase of—we went, actually, from in Pennsylvania totally, 24,000 in just the fee-for-service plan to almost 50,000 people in the last year. In my own district, we have gone from 1,000 to almost 4,000 beneficiaries.

Now, if you can say that they are actually getting more services, they are healthier, maybe we would be able to feel better about this. But what I want to tell you is that three of the major hospital systems in the Philadelphia area have decided to no longer accept the Medicare Advantage fee-for-service patients. Theoretically expanding choice; in fact, as is pointed out, we are seeing a denial of fewer hospitals taking it. These are not just hospitals here; they are really these health systems.

And they say the reasons that they are doing that are manyfold. But one of the principal reasons is that the beneficiaries and the providers do not know, when they refer to physicians, whether in fact those physicians will be covered. So there is greater—they don't know. They have no way of getting that information. The beneficiaries don't. The hospitals don't. So they make referrals, and they have no idea whether this is going to be an appropriate referral or not. They may show up at that physician's office, get the services, and have to pay 100 percent out of pocket.

So I ask this question because we are paying 20 percent more on average for these patients.

Mr. WEEMS. No.

Ms. SCHWARTZ. Well, I can tell you, in Pennsylvania the private fee-for-service plan in my district are paid, on average, 18 percent more than it costs to provide actually the same services to Medicare beneficiaries. That is the numbers we have. This is in southeastern Pennsylvania in my district. So we are paying 18 percent more, and people are going to see less care. They are seeing it already. And they are actually not getting the information to be able to make choices, and nor are their providers.

So this seems to me not just a bad idea but a disaster. So how do you defend that? How can you justify that as either good public policy or good healthcare, good outcomes, or anything that is positive? And some way we are going to fix this.

Mr. WEEMS. Thank you for the question. The first thing is, we know that—I would have to look at the private fee-for-service programs in your area. But for the most part, many provide protection against very high out-of-pocket costs. That is a protection that people get as a matter of insurance.

Now, it is true that providers don't have to accept private fee-for-service. And if it turns out that providers in that area aren't doing that, then people are going to leave those programs and go into products that are going to be much better for them. The plans have considerable outreach into the community.

Ms. SCHWARTZ. So how quickly can they make that change? Not quickly. Next year.

Mr. WEEMS. Next year.

Ms. SCHWARTZ. Right. So for a year, they may actually have no access to care.

Mr. WEEMS. Not no access to care. They may—

Ms. SCHWARTZ. Or possibly, if the hospital and the providers are not accepting it. They are stuck in a plan that has higher costs and no access to care. But they have choice.

Mr. WEEMS. I wouldn't suggest that it is even higher cost. They may be in a plan that has lower costs, and they—

Ms. SCHWARTZ. But it is theoretically possible they are in a higher cost?

Mr. WEEMS. Many things are theoretically—

Ms. SCHWARTZ. If they need more outpatient, for example, than hospital care, it could be higher cost for them during that year. And they could not change for a year.

Mr. WEEMS. Depending on which plan they chose. That is the nature of insurance, yes.

Ms. SCHWARTZ. Well, it is a very different ideology to say that we are moving this to a private insurance model rather than one where we are looking at for seniors, and we have said to seniors under Medicare, that we are going to help ensure that they have access to healthcare.

We would like it to be quality healthcare. We would like it to be cost-efficient. Right? And we think the taxpayers shouldn't have to pay more for less. But you are saying as long as they have choices, if they have made a bad choice, too bad. This is an insurance model.

Mr. WEEMS. Well, in many cases, the regular Medicare program may not be their best choice.

Ms. SCHWARTZ. It may not be. But the—

Mr. WEEMS. In which case it is just too bad there, too.

Ms. SCHWARTZ. Well let me add, and I will give back to the Chairman, but the idea here is not to say—I don't think any of us are saying, let's limit this to one option. We have never said that. We have talked about 11 Medigap plans. We have talked about the fact that even under Medicare Advantage, if we were paying the same and getting more benefits and people are getting better outcomes, it may even be worth paying more, although I think there is a lack of justification for why just some people should get that and not all.

But we are not talking about an either/or here. We are talking about better oversight. Accountability. Right? Knowing what we are doing. Making sure we are getting what we should for our taxpayer dollars. And that Medicare recipients are not actually disadvantaged by this rather than advantaged.

So it is simply not good enough to say, wait a minute. If we ask hard questions, you are going to say, well, then, we won't do any of it? That is not an acceptable answer.

Mr. WEEMS. If you are talking about reducing the payments, you are talking about an either/or situation in many parts of this country.

Chairman STARK. I want to try, if the gentlelady will yield, to let Dr. McDermott inquire—

Ms. SCHWARTZ. Thank you, Mr. Chairman, and thank you for your indulgence.

Chairman Stark.—before the votes ring down. Dr. McDermott?

Dr. MCDERMOTT. Thank you, Mr. Chairman. I appreciate your taking the time. And I just have a couple of questions.

My understanding from your report is that Medicare Advantage has a loss ratio of an average of 87 percent. Is that correct?

Mr. COSGROVE. That is correct, yes.

Dr. MCDERMOTT. And on the other hand, Medicare has a loss ratio of 98 percent. That is, 2 percent is going for administration, 98 percent going for benefits.

Mr. COSGROVE. According to the trustees, yes.

Dr. MCDERMOTT. According to the trustees. Do you trust the trustees?

Mr. COSGROVE. Absolutely.

Dr. MCDERMOTT. So where does this 11 percent go, or where does it come from, or how does it occur? I mean, we are paying insurance companies, and they are giving less care. They are taking 11 percent somewhere. Where does it go?

Mr. COSGROVE. Well, plans obviously have expenses that the traditional program doesn't have. Marketing expense—

Dr. MCDERMOTT. Like what? I mean, what is the benefit to the patient for those costs?

Mr. COSGROVE. Well, marketing expenses would be—but that is not a benefit to the patient.

Dr. MCDERMOTT. Well, you know, my mother is now dead. But I used to get about one a month of an advertising campaign for somebody, which I don't think did much for a 96-year-old woman. I really think—the thing that really puzzles me is that a third of those plans, as I understand it, have loss ratios less than 85 percent.

Mr. COSGROVE. That is correct.

Dr. MCDERMOTT. Can you give us the names of those?

Mr. COSGROVE. In discussions with CMS, CMS obviously considers these data proprietary and very sensitive. So no, what we—

Dr. MCDERMOTT. This is taxpayer money. What do you mean, proprietary? You mean the Congress can't know who is ripping old people off? We can't look at the data? Is that what you are telling us?

Mr. COSGROVE. Mr. Weems has the data, and it would be up to him to share it.

Dr. MCDERMOTT. It is up to CMS to give it to us. Is that right?

Mr. COSGROVE. They are the owners of the data. They shared it with GAO, and they gave it to us with some restrictions as to how we could report it.

Dr. MCDERMOTT. And on what basis, then, Mr. Weems, do you—how do you hold this data back?

Mr. WEEMS. These data are proprietary and may affect the competitive nature of the firms.

Chairman STARK. Is there any reason we couldn't see them in camera?

Mr. WEEMS. I believe we could make it available under those circumstances, sir.

Dr. MCDERMOTT. You believe we could. Is that a yes or a no?

Chairman STARK. It probably is a yes.

Mr. WEEMS. Yes. The answer is yes.

Dr. MCDERMOTT. So we got an actual yes out of you.

Chairman STARK. But you can't talk about it, now.

Dr. MCDERMOTT. Well, it is secret. That is right. Then we would be liable for suit. Is that right, if we talked about the data?

Mr. WEEMS. I am not an attorney. I couldn't say.

Dr. MCDERMOTT. See, the problem here is—

Chairman STARK. If you gave it to the New York Times, maybe you would.

Dr. MCDERMOTT. I know some guys at the New York Times. The fact is that we are—I admit I am a single payer advocate. I believe that a single payor system like Medicare is the way to go. And you are not giving me any reason—Mr. Kind asked on the basis of outcomes, which is what healthcare is supposed to be about. If you have healthcare, you are supposed to live longer than people who don't have outcomes.

So we have this Medicare Advantage. We pay them all this extra money. They should be getting better outcomes. But you have no data to prove that. All you have is 11 percent that is going into marketing and profits for insurance companies, I guess. I don't know where else it is going.

Mr. WEEMS. Congressman, through HEDIS data we do have outcome data, data that we don't have for the fee-for-service side.

Dr. MCDERMOTT. And can you share that data with us?

Mr. WEEMS. Of course we can. Absolutely.

Dr. MCDERMOTT. That is not proprietary?

Mr. WEEMS. No.

Dr. MCDERMOTT. I think the committee ought to be provided, Mr. Chairman, with that information so that we can actually look

at the proof that the Medicare Advantage program does any good for the heart of senior citizens because that is what this is really all about. It is not about choice and it is not—my mother didn't want choice at 97. She just wanted to know she could call up the doctor and go see him when she was sick.

Chairman STARK. Would the gentleman yield?

Dr. MCDERMOTT. Yes.

Chairman STARK. If you leave out dollars, copays, I don't think—and I would ask Mr. Weems—I don't think there is a plan in the country that has more choice of physicians and hospitals than Medicare. How many hospitals do you know that aren't in Medicare?

Mr. WEEMS. Very few.

Chairman STARK. How many doctors are not in Medicare? Not many. So, I mean, when you talk choice—

Mr. WEEMS. Well, that is one kind of choice, yes.

Chairman STARK. Yes, it is. But it is—

Dr. MCDERMOTT. It is the only choice that matters, Mr. Chairman.

Mr. WEEMS. Now, catastrophic costs matter, too.

Chairman STARK. Now, they may be limited by cost. That is a question, certainly. But on the other hand, some of the plans limit them by not recognizing the doctor—not having the doctor in the plan.

So in defending the plan that Mr. Weems runs so well called Medicare—

Dr. MCDERMOTT. Yes. We like that one.

Chairman STARK.—I would like to point out that he offers, what, 80 percent of us Medicare beneficiaries broad choice.

Mr. WEEMS. Well, we offer it to 100 percent.

Chairman STARK. Thank you very much for—

Mr. WEEMS. We offer it to 100 percent. Eighty percent take us up on the offer, sir.

Dr. MCDERMOTT. Both Mr. Stark and I are taking you up on it, and we enjoy it.

Chairman STARK. I want to thank—you can stay here after the vote ends, Doctor. But I am going to thank Mr. Cosgrove and Mr. Weems for their patience, their indulgence, their forthcoming testimony. We will have you back. I want to discuss this some more. And we will excuse you gentlemen, and thank you very much.

We will recess for approximately 15 minutes until we finish these votes. And if the second panel wants to come on up to the witness table or get a cup of coffee, we will be back and continue the hearing. Thank you.

[Recess.]

Chairman STARK. The committee will resume, and with apologies to the panel, who waited so patiently while Mr. Camp and I named three post offices after deserving citizens. And we can get back now to the important matters at hand.

We are privileged to have with us Dr. Byron Thames, who is a member of the board of directors of the AARP from Orlando, Florida; Mr. Mattes—do I pronounce that—

Mr. MATTES. Mattes.

Chairman STARK. Mr. James Mattes, who is president and CEO of the Grande Rhode or Rhode——

Mr. MATTES. Grande Ronde.

Chairman Stark.—Grande Ronde Hospital of La Grande, Oregon; Mr. David Lipschutz, who is interim president and CEO of the California Health Advocates in Los Angeles; and Dr. Daniel C. Lyons who is senior vice president, government programs, of the Independence Blue Cross in Philadelphia, Pennsylvania.

I will ask you gentlemen if you would like to proceed in the order that I recognized you. And without objection, all of your prepared testimony will appear in the record. And if you would like to expand on it or enlighten us in any way, and then we can further get information during our inquiry.

Dr. Thames?

STATEMENT OF BYRON THAMES, M.D., MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, ORLANDO, FLORIDA

Dr. THAMES. Thank you, Mr. Chairman, members of the committee. I am Byron Thames, a physician member of the board of directors of AARP. We thank you for the opportunity to present AARP's views on the Medicare Advantage program.

Let me begin by reaffirming a core principle. AARP is committed to the Medicare program. It is a vital component of financial retirement security for older Americans and many with disabilities.

I also want to reiterate our support for Medicare Advantage. We believe it is important for people on Medicare to have genuine choices of how they receive services. To this end, beginning this year, most of United Health Care's coordinated care Medicare Advantage plans will carry the AARP name.

We emphatically believe choices must be genuine. Options should differ from one another and each offer high quality services. AARP believes that MA coordinated care plans hold the promise of improving the quality of care.

We are less sanguine about the private fee-for-service option. We did not support its inclusion in Medicare because, one, these plans are not required to coordinate care for their enrollees or participate in quality improvement activities, two key requirements for other MA options. And two, these plans can set their own fee schedules and are not subject to Medicare's important balanced billing rules.

In addition, the marketing of these plans is fundamentally confusing to many beneficiaries. Just last week AARP was contacted by an anxious member. The hospital where her husband was scheduled for surgery would not accept his coverage once they learned that he was enrolled in a private fee-for-service plan.

This member didn't realize that the plan she enrolled in was not a supplement to traditional Medicare. She believed that she would still be able to freely choose doctors and hospitals. The marketing materials did not make the difference between traditional Medicare and the private fee-for-service plan clear.

There are numerous reports of fraudulent marketing where beneficiaries have received inaccurate or misleading information about private fee-for-service plans. AARP urges action that will put a stop to these practices once and for all.

We commend CMS for the steps it took last summer to curtail questionable tactics, but further steps are needed. My written statement includes specific recommendations intended to improve consumer protections in the Medicare Advantage market.

AARP also believes that Medicare Advantage plans should coexist with the traditional program on an equal footing. Currently, payment rates are, on average, skewed in favor of MA plans. This does not make economic sense for the program or for the people in traditional Medicare, who pay higher premiums for benefits they do not enjoy.

MedPAC reports that, on average, payments to private fee-for-service plans exceed payments in the traditional program by 17 percent. We see no justification for the substantial excess payments.

Furthermore, because private fee-for-service plans are not required to coordinate care or participate in quality improvement activities, we question what value these plans bring to Medicare. It is not unreasonable to expect coordinated care plans to operate efficiently.

We know that many beneficiaries appreciate the extra benefits and most cost-sharing that some MA plans offer. But these advantages should derive from savings from high quality care, eliminating waste and needless care, and cost-effective plan operation, not from Medicare excess payments that favor only the 20 percent of beneficiaries who have elected MA enrollment.

AARP strongly concurs with the MedPAC recommendation of payment neutrality for all Medicare coverage options. Payments can be reduced gradually, without undermining beneficiaries' confidence in MA.

In summary, it is fair and reasonable for Medicare Advantage plans to bring real value to Medicare by providing high quality, cost-effective, and efficient care. We look forward to working with you and your colleagues on both sides of the aisle on policies that improve the options offered to Medicare beneficiaries. Thank you, Mr. Chairman.

[The statement of Byron Thames follows:]

**Statement of Byron Thames, M.D., Member, Board of
Directors, American Association of Retired Persons,
Orlando, Florida**

Mr. Chairman and members of the Committee I am Byron Thames, a member of the AARP Board of Directors. AARP appreciates the opportunity to present our views on the Medicare Advantage program.

Let me begin by reaffirming a core principle: AARP is committed to the Medicare program and believes it is essential that Congress continue to strengthen and improve Medicare for current and future beneficiaries. Medicare is a vital component of financial security for older Americans and many with disabilities, and we must ensure that the program continues to remain a viable and responsive part of retirement security for all Americans.

I also want to reiterate our support for the Medicare Advantage program. We believe that it is important for people on Medicare to have genuine choices when it comes to how they receive Medicare benefits. To this end, beginning this year most of UnitedHealthcare's coordinated care Medicare Advantage plans will carry the AARP name.

However, while we support a choice of coverage options, we emphatically believe that the choices must be genuine, that the options differ from one another and, most importantly, that each option offers high quality services.

AARP believes that MA options in Medicare have the potential to bring real value to the program. The coordinated care plans available through Medicare Advantage in the form of health maintenance organizations (HMOs) and preferred provider organizations (PPOs) hold the promise of offering innovations in care delivery that can improve the quality of care as well generate savings. We know that many of our members enjoy the opportunity for care coordination available through integrated health plans, and we recognize that these types of plans can marshal resources to provide comprehensive care.

Private Fee for Service Not a Good Option for Medicare

We are less sanguine about the private fee-for-service (PFFS) option and did not support its inclusion as a Medicare coverage option. AARP does not support PFFS for several reasons. PFFS plans are not required to coordinate care for their enrollees or participate in quality improvement activities—two key requirements for other MA options. Further, PFFS plans can set their own fee schedules—not subject to Medicare’s important balance billing rules. And PFFS plans are not required to offer Part D prescription drug coverage.

PFFS plans are also fundamentally confusing to beneficiaries. A PFFS plan appears to resemble the traditional Medicare program because enrollees can theoretically choose their providers. But this is not really the case. Enrollees cannot know in advance whether the doctors or hospitals they want to use will accept payment from a PFFS plan. Just last week, AARP was contacted by an anxious member who found that the teaching hospital where her husband was scheduled for surgery would not accept his coverage once they learned that he was enrolled in a PFFS plan. In talking to our member, it was quite clear that when she enrolled in her PFFS plan, she did not realize that this was not a supplement to traditional Medicare as she had purchased in the past. She believed that she would still be able to freely choose doctors and hospitals. She was confused by the apparent similarity between PFFS and the traditional Medicare plan because the marketing materials upon which she relied did not make the difference clear.

Unscrupulous Marketing Tactics Must Be Stopped

There is abundant research, including studies that were commissioned by AARP’s Public Policy Institute, that demonstrate that Medicare beneficiaries do not have an adequate understanding of the differences among Medicare’s coverage options. A recent study by investigators at the Research Triangle Institute concluded that an increased number of plan choices complicate the health plan decision making process for beneficiaries. This often leaves some beneficiaries vulnerable to questionable marketing practices. Here again, PFFS plans are often a problem. State regulators and beneficiary advocates have reported numerous incidents of fraudulent marketing where beneficiaries have received inaccurate or misleading information about PFFS benefits and charges. Some of the marketing problems did occur in other MA plans as well. State regulators have expressed frustration that they are not able to pursue these incidents. AARP urges action that will put a stop to these practices once and for all.

We commend CMS for the steps it took last summer in its effort to curtail questionable tactics used to move beneficiaries into MA plans. But we think further steps are needed. In testimony before the Medicare Private Plans SubGroup of the National Association of Insurance Commissioners in September, 2007, AARP made several recommendations intended to improve consumer protections in the MA market. These include:

- Outbound education and verification calls should be made to all new enrollees in Medicare private plans to ensure that beneficiaries understand plan rules. These rules should apply to PFFS as well as other MA options.
- CMS should develop a mandatory national standardized Medicare training program for all agents who sell Medicare products. All such representatives should be required to pass a written test, based on standardized training, that demonstrates their thorough familiarity with Medicare and Medicare products (MA, PDP, Medigap) and how Medicare interacts with other coverage such as Medicaid, retiree health, VA, etc.
- NAIC should develop model regulations, setting standards for agent conduct, and defining prohibited activities with respect to the sales and marketing of MA plans. CMS and the States should adopt these regulations, which would allow both the State and Federal Governments to enforce them. The guidelines should include standard timelines for CMS and the States to render decisions.
- CMS and/or NAIC should continue “secret shopper” programs to determine whether their rules are followed by agents and plans.

- CMS, together with the States and the NAIC, should create a national database to provide and share information about agents and brokers who have been sanctioned or terminated by a health plan and for use in screening agents.
- The financial incentives or commissions that individual brokers receive based on the type of product they sell (e.g., MA, PDP, etc) should be publicly disclosed on the CMS website and presented to a beneficiary before enrollment. A beneficiary should have the right to know if an agent has a financial incentive to recommend one product over another.
- The same marketing and enrollment requirements should apply to all MA plans. PFFS should not have an unfair advantage in the marketplace, such as the extended open enrollment period that they now enjoy.
- Special consideration should be given to the marketing of PFFS plans to dual eligibles. There have been widespread reports of dual eligibles who did not understand the consequences of their decision to join a PFFS plan and have lost important Medicaid benefits. Because of the special enrollment rules for dual eligibles (i.e., they can enroll on a monthly basis), they have been targets of abuse.
- CMS and the States should vigorously enforce guaranteed issue protections that apply when agents misrepresent MA plans. Consumers who disenroll from an MA plan who wish to enroll in traditional Medicare within a certain period of time should have the opportunity to purchase Medigap. If someone had a Medigap policy other than one of the guarantee issue plans, he/she should be allowed to return to it with no break in coverage, and retroactively pay premiums for the elapsed period.

Improvements Needed In Medicare's Payment of MA Plans

As noted earlier, AARP supports MA plans in the Medicare program. But we think they should co-exist with the traditional program on an equal footing. Currently, payment rates are, on average, skewed in favor of MA plans. This does not make economic sense for the Medicare program, nor is it fair to people on Medicare who opt for coverage in the traditional plan. The payment discrepancy between traditional Medicare and PFFS plans is particularly troublesome. The Medicare Payment Advisory Commission (MedPAC) reports that, on average, payments to PFFS plans exceed those Medicare makes on behalf of beneficiaries in the traditional program by 17 percent. The Commission cites two reasons: first, insurers offering PFFS plans tend to operate where payment rates are especially favorable, notably suburban and rural areas; and second, because their bids are relatively high, signaling more costly operations than those of HMOs, for example. In light of the fact that PFFS plans are not required to coordinate care for their enrollees and are not required to participate in quality improvement activities, such as reporting HEDIS quality data, we question what value these plans provide to Medicare. Furthermore, we see no justification for the substantial excess payments.

HMOs were first introduced to Medicare because it was widely assumed from the experience of pre-paid group practice plans like Kaiser, Group Health Cooperative of Puget Sound, and others that by receiving a capitated payment, plans could oversee and manage care and operate efficiently. In fact, in the early days of the program, it was expected that private health plans would be able to operate with at least 5 percent less in payment than traditional Medicare. AARP believes that it is still not unreasonable to expect coordinated care plans to operate efficiently and cost effectively. We know that many beneficiaries appreciate some extra benefits and modest cost-sharing that many MA plans offer. But we believe that these advantages should derive from savings that accrue from high quality care, eliminating waste and needless care, and cost effective plan operation—not from Medicare excess payments that favor only the 20 percent of beneficiaries who have elected MA enrollment.

As a policy matter, AARP strongly concurs with the MedPAC recommendation of payment neutrality for all Medicare coverage options. To rectify the situation excess payments can be reduced gradually without undermining beneficiaries' confidence in MA, and without causing plans to precipitously withdraw from Medicare or dislocating or inconveniencing beneficiaries.

In summary, AARP continues to support plan choices that include MA plans. However, we are convinced that it is fair and reasonable for these plans—particularly PFFS plans—to demonstrate that they bring real value to Medicare by demonstrating measurable advantages in the form of high quality and cost-effective and efficient care. We look forward to working with you and your colleagues on both sides of the aisle on policies that improve the options offered to Medicare beneficiaries.

Chairman STARK. Thank you, Doctor.
Mr. Mattes?

**STATEMENT OF JAMES A. MATTES, PRESIDENT AND CEO,
GRANDE RONDE HOSPITAL, LA GRANDE, OREGON**

Mr. MATTES. Good morning, Mr. Chairman and members of the subcommittee. Thank you for inviting me here today to tell the story of our hospital's experience with Medicare Advantage plans.

Grande Ronde Hospital is a community-owned, not-for-profit, 25-bed critical access hospital. We are located in the beautiful Blue Mountains of northeast Oregon in remote, rural, and isolated Union County.

The closest tertiary facilities are located over mountain passes in Boise, Idaho, 177 miles to the east, and Portland, Oregon, 259 miles to the west. The three closest hospitals are an hour or more away, providing the weather is good. Travel during the winter months is treacherous, and a normal winter storm can shut down the highways for hours.

My priority first concern is for the people we care for in our hospital. A large number of seniors who have enrolled in Medicare Advantage plans, about one-quarter by our count, do not realize they have opted out of traditional Medicare. The senior citizens and providers of Union County are overwhelmed with 21 Medicare Advantage plans. We routinely counsel and assist confused and frustrated beneficiaries, many of whom thought they were signing up for a Medicare supplement, drug benefits, or some other supplemental coverage.

Our experience with beneficiaries also shows that Medicare Advantage plans are unresponsive when it comes to resolving problems or answering routine questions about coverage. Poor customer service by multiple plans leaves my staff picking up the slack in helping seniors to resolve claim and coverage issues. This means my hospital is effectively helping foot the bill for these plans, while at the same time they are being paid more than traditional fee-for-service Medicare.

Also, some senior citizens end up subsidizing Medicare Advantage plans. Several of our sickest and poorest patients, who require frequent care, end up paying more out of their own pockets because of daily hospital and home health co-payments. You can imagine how upset a patient can be when on top of the trauma and anxiety that an illness or injury can cause, they must pay more out of pocket than they had anticipated.

The consumer advisory unit of the Oregon Insurance Division recently issued a consumer alert advising seniors that some unscrupulous insurance agents are preying on seniors by using misleading tactics. Many of the abuses are occurring in the marketing and selling of Medicare Advantage plans.

One example of such abuse in Union County is a churning of Medicare plans sold to seniors. Observations on the part of my billing staff suggest that the majority of Medicare Advantage enrollees are sold a new plan every year.

Beneficiaries also are swept into problems created by Medicare Advantage plans. These plans have unusually high error rates, which delay the payment of claims and frustrate beneficiaries and providers.

In a recent routine compliance audit, our facility randomly sampled Medicare Advantage payments and found the insurance carrier payment error rate exceeded 38 percent. Our hospital staff must review every claim for accuracy, and often must spend weeks or even months making phone calls and writing letters to straighten out a patient's account.

When they do finally decide to pay a claim, they do not pay us electronically even though the claim was made electronically. Compared to traditional Medicare, it takes roughly three times as long to receive payment, which compromises provider cash flow.

Mr. Chairman, I want to take a step back for a minute and look at the impact of Medicare Advantage on providers, and then I will close. The capitated rates paid to Medicare Advantage carriers in many rural communities are well above costs. With the mission of maximizing profits, Medicare Advantage insurance carriers have a strong incentive to focus their marketing efforts on the most profitable regions of the country, which may explain the extraordinary levels of enrollment in Union County, Oregon.

As enrollment grows in the Medicare Advantage, I am concerned these carriers will use market leverage to force discounts in provider payments, which will hurt small and rural hospitals and, ultimately, the patients who depend on us for medical care.

Mr. Chairman, I conclude by saying, quite simply, America's elderly and disabled deserve better. Medicare Advantage plans confuse and frustrate them, and poor communications and poor support leave them feeling abandoned. In many cases, they are unable to make an informed decision. Beneficiaries often end up bearing risk without an adequate understanding of whether or not they may be better off financially if they stayed with traditional Medicare.

Rural hospitals and physicians also deserve better. The unchecked growth of Medicare Advantage plans and their rapid displacement of traditional Medicare is disrupting the healthcare mission of hospitals and physicians. Medicare Advantage plans underpay critical access hospitals in defiance of congressional intent. For Grande Ronde Hospital, this could soon exceed one million dollars per year.

To sum up, these plans are hurting rather than helping some seniors and hospitals, and they are increasing the cost of care for everyone. Thank you.

[The statement of James A. Mattes follows:]

**Statement of Jim Mattes, President and CEO,
Grande Ronde Hospital, La Grande, Oregon**

Chairman Stark and distinguished members of the Committee, thank you for inviting me here today to share with you Union County, Oregon's experience with Medicare Advantage plans. I am Jim Mattes, President and Chief Executive Officer of Grande Ronde Hospital in La Grande, Oregon, where I have served for the past 24 years.

My testimony draws on my community's experience and my hospital's experience with Medicare Advantage plans in Union County, Oregon. It is my hope that by sharing our experiences you will be able to see the adverse impact and long term

consequences Medicare Advantage plans will have on beneficiaries, Critical Access Hospitals, and the healthcare system.

Union County, Oregon (2000 U.S. Census)

Union County, Oregon has a population of approximately 24,530 people, dispersed over 2,039 square miles. Per capita income in Union County is \$16,907. About 13.8% of the population is below the poverty line, including 9.5% of the population age 65 and over.

The County seat is La Grande, a small community of 12,327 people. We reside in the Blue Mountains of Northeast Oregon, a remote rural part of the State, with 4,000+ foot elevation mountain passes in every direction. Travel during the winter months is treacherous, with winter storms sometimes closing our highways and making it impossible for people to leave the community.

Grande Ronde Hospital

Grande Ronde Hospital is a community owned, not-for-profit, 25-bed Critical Access Hospital (CAH). The closest tertiary facilities are located over mountain passes in Boise, Idaho (177 miles to the East) and Portland, Oregon (259 miles to the West). The closest hospitals are St. Elizabeth (42 miles to the East), St. Anthony (50 miles to the West), and Wallowa Memorial (68 miles to the North). Patients requiring transfer to a larger medical facility must travel two to four hours by ground ambulance.

In order to sustain access to local medical services, our hospital has recruited and employed 12 primary care providers (i.e. ten physicians and two nurse practitioners) who practice in three provider-based clinics which are fully integrated with the hospital. Accordingly, our hospital's experience with Medicare Advantage plans is amplified by the fact that our provider-based clinic revenue is integrated with hospital revenue, and our hospital-owned clinics currently care for the majority of Medicare patients in our community.

Medicare Demographics in Union County, Oregon (2000 U.S. Census)

Union County's age 65 and older population of 3,949 makes up 16.1% of the County's total population. Insurance agents in La Grande claim to have enrolled approximately 1,500 of these seniors into Medicare Advantage plans. This currently represents 38% of the County's Medicare population. Based on the rapid growth in Medicare Advantage enrollment in Union County we project that within two years Medicare Advantage enrollment could be 2,500 or 63% of our Medicare population. [See EXHIBIT 1: Medicare Enrollee Estimates]

Medicare Advantage Plans are Hurting Union County Seniors

A large number of seniors who have enrolled in Medicare Advantage plans in Union County do not realize they have opted out of traditional Medicare—a frequent problem that we estimate occurs with one out of every four Medicare Advantage enrollees. At Grande Ronde Hospital, we routinely counsel and assist confused and frustrated beneficiaries. It is not uncommon to encounter patients who do not realize they have joined a Medicare Advantage plan. They simply thought they were signing up for a Medicare supplement, Medicare drug benefits or some other form of additional coverage. Beneficiaries are often upset to learn that they no longer have traditional Medicare coverage and that the “low cost” plan they opted for could potentially cost them more out of pocket than traditional Medicare.

Illustration #1: Mr. Johnson (not his real name) pays more out of pocket

Mr. Johnson signed up for the Advantra Freedom Medicare Advantage plan, believing he had purchased a Medicare supplement and that he still has traditional Medicare. On December 1st he was admitted to our hospital for 8 days and was discharged on December 9th. On December 15th Mr. Johnson was re-admitted to our hospital for 5 days and was discharged on December 20th.

Mr. Johnson's out of pocket expenses are analyzed below.

Cost under Medicare Advantage Plan (Advantra Freedom 5)

- \$900.00 First Stay (\$180/day 1–5 days)
- \$900.00 Second Stay (\$180/day 1–5 days)
- \$55.00 Monthly Advantage plan premium
- \$96.40 Medicare Part B Monthly Premium (paid in addition to Medicare Advantage Plan premium)

TOTAL OUT OF POCKET: \$1,951.40

Cost under Traditional Medicare:

- \$1,024.00 Part A Deductible (\$1,024.00 every 60 days)
- \$96.40 Part B monthly premium
- \$120.00 (20% Part B co-pay, since Part B charges total \$600.00 for both stays).

TOTAL OUT OF POCKET: \$1,240.40

As the information above illustrates, Mr. Johnson paid an additional \$711.00 out of pocket with his Medicare Advantage plan coverage than he would have under traditional Medicare coverage.

There are eight Medicare Advantage insurance carriers and 21 different plans in Union County for which our hospital and clinics have treated patients, and there are reportedly others being sold. [See EXHIBIT 2: Medicare Advantage Plan Growth; and EXHIBIT 3: Medicare Advantage Plan Options] Too many carriers, too many plans and too many benefit variables make due diligence comparison difficult and confusing, especially for the elderly—a setting that is vulnerable to abuse. The Consumer Advocacy Unit of the Oregon Insurance Division issued a “Consumer Alert” advising seniors to beware of abusive Medicare insurance sales practices, and included the following statement in their brochure for seniors: “. . . some unscrupulous insurance agents are preying on seniors by using tactics that are confusing and misleading. Many of the abuses are occurring in the marketing and selling of Medicare Advantage plans . . . ” One such apparent abuse in Union County is the annual “churning” of Medicare Advantage plans sold to seniors. Our hospital billing staff estimates that the majority (more than 50%) of Medicare Advantage enrollees are sold a new plan each year by insurance agents reportedly going door-to-door. The churning of plans adds to the confusion and frustration of beneficiaries as they struggle with knowing which carrier is responsible for which claim.

Anecdotal Story #2: Mr. Jones (not his real name) is unhappy

Mr. Jones comes to the hospital ER admitting for medical treatment and presents both his Medicare and Medicare Advantage insurance cards. He insists that the Medicare Advantage plan is his secondary insurance. In an effort to avoid a dispute over coverage, the admitting clerk enters both plans into the system.

When the billing department receives the patient’s insurance information they realize that the patient cannot have both traditional Medicare and Medicare Advantage coverage, so the patient account representative calls the patient.

Mr. Jones insists that he has both plans—despite all efforts to convince him otherwise. Eventually the patient account representative assures a very upset Mr. Jones that she will determine which insurance was in effect at the time the services were rendered and that she will call the patient back. Mr. Jones leaves the hospital very fearful that he may have lost his traditional Medicare coverage and simply does not understand what is going on.

The patient account representative calls the insurance carrier. After spending 20 minutes on hold, the call is answered by an individual who struggles with English. With some difficulty, the patient account representative manages to confirm that the patient had Medicare Advantage coverage at the time the services were rendered. The patient account representative subsequently calls Medicare to verify that they have a record of the patient’s Medicare Advantage plan coverage. Medicare has no record of any other coverage, and reminds the patient account representative that CMS requires that only beneficiaries may update their records via phone, and the account representative is not permitted to act on their behalf. Since the patient is not present to put on the phone, the patient account representative is unable to verify coverage information.

The patient account representative next contacts the patient and explains the situation to him, at which point Mr. Jones becomes very upset that he has lost his Medicare coverage and decides that he wants to terminate his Advantage plan membership.

After several frustrating calls to the Advantage plan without results, Mr. Jones brings all his paperwork to the hospital billing department and asks the patient account representative for help with terminating his Advantage plan coverage. Several phone calls and 45 minutes later the patient’s Advantage plan coverage was successfully terminated and he is again covered by traditional Medicare.

The hospital billing department may now submit the ER bill to the Medicare Advantage plan for payment. Bills for any services rendered after the date on which the Medicare Advantage plan is terminated will be billed to traditional Medicare.

As previously noted, Union County is a poor county with 9.5% of its senior population below the poverty line. Because of this demographic, Medicare Advantage plans with reduced deductibles appeal to seniors in our market. Unlike traditional Medicare, some Medicare Advantage plans impose daily hospital copayments and daily copayments for home health visits. Sadly, some of our sickest beneficiaries

who require frequent care end up paying more out of pocket cost than traditional Medicare.

Medicare Advantage plans also do a poor job of handling enrollee problems with claim and coverage questions. Insurance agents are not always available to beneficiaries to answer questions and resolve problems after a sale is finalized, and most of the Medicare Advantage plans operating in Union County have outsourced their customer service departments to foreign countries. When beneficiaries have a problem with a claim or want to discontinue their plan, they often have difficulty connecting with customer service personnel and routinely experience communication problems, including difficult language and accent barriers. Poor customer service, as illustrated in story #2 above, often results in our hospital and clinic employees being called upon to help seniors resolve claim and coverage issues. In doing so, we are effectively subsidizing these Medicare Advantage plans.

Medicare Advantage Plans are Hurting Providers in Union County, Oregon

While the focus of my comments relate to beneficiaries, I do want to mention several issues that our medical community is now facing with the explosion of Medicare Advantage plans in our area.

There are two types of Medicare Advantage plans, Preferred Provider Organization (PPO) plans and Private Fee-for-Service plans. Both types of plans appear to have unfair leverage against rural providers. The capitated rates paid to Medicare Advantage carriers in some areas of the country, particularly in the rural western United States, are well above costs. With the mission of maximizing profits, Medicare Advantage insurance carriers have a strong financial incentive to focus their marketing efforts on the most profitable regions of the country, resulting in a disproportionate enrollment of rural Medicare beneficiaries. This may help explain the extraordinary levels of enrollment in Union County, Oregon.

Medicare Advantage PPO plans pursue contractual relationships with providers, hoping to make them members of a PPO network. Grande Ronde Hospital has only one Medicare Advantage PPO contract, with negotiated payment rates which are nearly identical to the rates paid by Private Fee-for-Service plans in Union County. As with other commercial PPOs with a significant market presence, Grande Ronde Hospital is concerned that as enrollment grows, Medicare Advantage PPO carriers will use market leverage to force discounts in payment rates. Discounted payment rates for services provided to Medicare beneficiaries, hurt small and rural hospitals and undermine the Critical Access Hospital safety net intended by Congress.

The other seven Medicare Advantage insurance carriers operating in Union County all sell Private Fee-for-Service plans. These carriers have forced Grande Ronde Hospital into becoming what is called a “deemed” provider. This means that without signing a contract, our hospital has agreed to accept the plan’s terms and conditions for a particular plan enrollee for a particular visit or admission, simply by treating a patient covered by one of these plans. Provider choices with Private Fee-for-Service plans are limited as follows: (1) provide the care these patients need and by doing so become a deemed provider or (2) refuse to provide treatment, but still comply with Emergency Medical Treatment and Active Labor Act (EMTALA) law. If Grande Ronde Hospital were to refuse to provide treatment, then these patients would be forced to leave town for their medical care. For the sake of our patients, the financial welfare of our hospital, and the good of our community we truly have no choice but to care for these patients. In our isolated rural setting with travel in and out of the community periodically shut down due to winter storms, a refusal to provide treatment could have serious consequences.

Medicare Advantage Private Fee-for-Service plans sold in Union County are permitted to operate without a contracted network of providers. These plans are supposed to pay providers what Medicare would have otherwise have paid if the patient were a traditional Medicare patient. However, for CAH providers whose payments are “cost-based” under traditional Medicare, Medicare Advantage insurers are paying us the Medicare interim payment rate (i.e. the prior year cost-to-charge ratio plus 1%). Medicare Advantage insurers do not provide an inflation adjustment or a settlement process to reconcile actual costs against the interim rate, such as is proposed by Representative Ron Kind in the Rural Health Services Preservation Act. [H.R. 2159: “. . . Although this CAH reimbursement system was enacted by Congress to preserve access to hospital services for our rural seniors, many CAHs do not receive payments at these levels today for providing care to beneficiaries enrolled in the Medicare Advantage program. H.R. 2159 would ensure that CAHs are reimbursed at the same levels by private Medicare Advantage plans as they receive under the traditional Medicare program for inpatient, swing-bed, and outpatient hospital services.”] Traditional Medicare retrospectively reimburses CAH providers based on “actual costs” following the conclusion of each fiscal year, with the actual

cost-to-charge ratio becoming the new interim rate for the subsequent fiscal year. Medicare Advantage plans do not provide an adjustment for inflation and there is no look-back (i.e. reconciliation of actual costs against the interim rate) which can capture any increase in the actual cost-to-charge ratio.

Grande Ronde Hospital's cost-to-charge ratios have been increasing in each of the past several years, including a 3.8% increase (i.e. 66.14% to 69.94%) from FY2007 to FY2008. This means Medicare Advantage plans have underpaid us by an amount equal to 3.8% of patient charges, because there is no inflation adjustment or retrospective cost settlement process. [See EXHIBIT 4: Ratio of Cost to Charges] Many CAH providers have cost-to-charge ratios that are increasing, which typically occurs when net operating margins are declining. Grande Ronde Hospital's 3.8% jump in its cost-to-charge ratio from FY2007 to FY2008 illustrates the significant financial impact which underpayment by Medicare Advantage plans can have on CAH providers. [See EXHIBIT 5: Medicare Advantage Plan Revenue; and EXHIBIT 6: Medicare Advantage Plan Underpayment Estimates] To this point in time, Grande Ronde Hospital has been able to absorb these underpayments, but in the future that may not be true for us or other CAH providers who are impacted by such cuts. It is well publicized that Medicare Advantage insurance carriers are making big profits because of the disparity between capitation payments and actual costs. However, few people know and understand that Medicare Advantage carriers are also making profits on the backs of small and rural hospitals as they force payment rates on providers which are below traditional Medicare payment rates. Even my hospital was caught off guard. It was my preparation for this hearing, over the past two weeks, that fully brought to light the magnitude of the shocking rise in Medicare Advantage enrollment in Union County and the impact that Medicare Advantage underpayment is having on my hospital.

Another problem with Medicare Advantage plans is their very high payment error rates, which adversely impact provider productivity and increase healthcare costs. In a recent routine compliance audit we randomly sampled Medicare Advantage payments and found the insurance carrier payment error rate was 38.46%. Our hospital staff must review every claim for accuracy and often must literally spend weeks or even months of manual follow-up via multiple letters and phone calls to receive accurate payment for services rendered to beneficiaries.

Poorly developed Medicare Advantage electronic or manual billing and claims processing systems also adversely impact hospital productivity and increase healthcare costs. All eight of the Medicare Advantage plans in Union County accept electronic billing, but none of them pay electronically, which appears to be an intentional method of improving Medicare Advantage carrier cash flow at the expense of providers. At my facility, Medicare Advantage claims are paid on average within 45 days of submission of a clean claim, compared to traditional Medicare where a clean claim is often paid within 14 days of submission. This has caused a 6.65% increase (i.e. \$292,417) in Medicare accounts receivable, and it has compromised our cash flow.

Anecdotal Story #3: Hospital billing problems with Mr. Smith (not his real name)

Mr. Smith is admitted to the hospital on December 25, and is an inpatient until January 4th. When Mr. Smith presented to the admitting department he provided his "Secure Horizons" Medicare Advantage card.

After discharge the hospital billing department submitted Mr. Smith's bill to Secure Horizons. Forty-five (45) days after claim submission, a denial is received via U.S. mail. The denial states "beneficiary not covered on these dates of service".

The patient account representative phones the patient and notifies him of the denial and questions his coverage dates. The patient explains that effective January 1 he has a new Medicare Advantage plan with "Today's Options". The hospital biller must now "split bill" this service, sending the bill for the first portion of the patient's stay to Secure Horizons, and the bill for dates of service after January 1 to the Today's Options. Each of the bills are subsequently paid 45 days after submission, a total of 90 days in accounts receivable from date of discharge to final payment.

Had the Medicare Advantage plan been subject to the same electronic payment rules as Medicare, the original claim denial would have been received 14 days after claim submission, and both claims would have been paid in full (provided there were no other errors) roughly 28 days after the first claim submission. [Total days for payment: Medicare Advantage vs. Traditional Medicare (90 days vs. 28 days).]

Inefficiencies and increased workload caused by Medicare Advantage plans has required significant additional man hours from billing and collection staff, accounting and administration. Our costs have increased in response to all of the following: assisting the elderly with their complaints, plans, benefits and claims; managing 21

plans in addition to traditional Medicare, which sometimes require split billing; resolving frequent payment errors; and managing their slow payment practices. You may be surprised to learn that the additional payroll expense caused by Medicare Advantage plans are allowable costs on the traditional Medicare cost report for CAH hospitals, which means that Medicare is unwittingly subsidizing Medicare Advantage plans through the back door. Unfortunately for us, Medicare only reimburses each hospital based on the ratio of Medicare volume to total volume and the majority of these added costs must be shifted to other carriers or subtracted from the hospital's bottom line.

SUMMARY

Senior citizens deserve better. They are confused and frustrated by the many benefit packages offered by Medicare Advantage plans; the elderly are often unable to resolve problems and make informed decisions because of poor plan communications and plan support; and some Medicare beneficiaries would be better off financially if they stayed with traditional Medicare. Medicare Advantage plans are structured so that enrollees are taking risk, but without an adequate understanding of the risk they are taking. Congress needs to assure that seniors are well-informed, decision making is made simple, and risks are mitigated.

Rural hospitals and physicians also deserve better. The frightening growth of Medicare Advantage plans and their rapid displacement of traditional Medicare are having an adverse impact on our local healthcare system. Medicare Advantage plans appear to have unfair leverage against small and rural communities where costs are well below capitation rates, and they underpay CAH providers. The very high payment error rates, the delay in payments to providers, and the increased workload these plans impose on providers are collectively undermining the integrity of the Medicare program and increasing the cost of healthcare.

Congress passed legislation to protect CAH providers and ensure access to care in rural communities. Somehow, it would appear, the Medicare Advantage program has been allowed to circumvent congressional intent.

Chairman STARK. Thank you.
Mr. Lipschutz?

STATEMENT OF DAVID LIPSCHUTZ, INTERIM PRESIDENT AND CEO, CALIFORNIA HEALTH ADVOCATES, LOS ANGELES, CALIFORNIA

Mr. LIPSCHUTZ. Chairman Stark, Ranking Member Camp, distinguished committee members, thank you for the opportunity to testify today. My name is David Lipschutz, and I am interim president, CEO, and staff attorney of California Health Advocates, an independent nonprofit organization dedicated to education and advocacy efforts on behalf of Medicare beneficiaries in California.

Our experience with Medicare is based in large part on our close work with California's State health insurance program known in our State as HICAP, which is on the front line assisting Medicare beneficiaries. Of the various options within the Medicare program to access benefits, we recognize that some Medicare Advantage plans can work for some individuals.

Other Medicare beneficiaries, however, can be disadvantaged by joining MA plans for a variety of reasons, including restriction of access to providers, high out-of-pocket expenses, and other barriers to care such as utilization management.

My testimony will briefly focus on general issues faced by MA plan enrollees, new insurance products being sold to fill in the gaps of MA plans, and the experience of dual eligibles who enroll in MA plans.

The staggering rise in the number, type, and variation of MA plans over the last two years, coupled with aggressive and mis-

leading marketing, has greatly hindered the ability of Medicare beneficiaries to make informed decisions about how they want to access their Medicare benefits.

Many beneficiaries are lured by MA plans with zero or low monthly premiums, corresponding offsets of their Part D premium, and extra benefits of often limited value. Once enrolled and in need of services, however, many find they are liable for cost-sharing on a par with or even greater than original Medicare.

Since MA cost-sharing is commonly downplayed during sales, those with chronic conditions can face catastrophic costs they hadn't anticipated, and realize too late that they would have been better off financially by purchasing a Medigap policy.

For example, a HICAP counselor in southern California, who has extensive experience working with individuals with cancer, reports that most MA plans she deals with are charging at least 20 percent in cost-sharing for chemotherapy and radiation. Enrollees in these plans who receive cancer treatment often have thousands of dollars in monthly out-of-pocket expenses.

Most cancer patients in this situation report that when they signed up with their MA plan, they thought that the co-payments for chemo would be between \$35 and \$50. Many tell the counselor that they would rather die than leave their families without money.

Some who join MA plans are surprised to learn that providers who they had seen for years are not members of the plan's network or, particularly in the case of private fee-for-service plans, refuse to accept the plan's terms and conditions, leading to problems finding doctors who will treat them.

Over the last year, much attention has been focused on appalling abuses surrounding the sale of Medicare Advantage plans. Despite this attention, though, we believe that far too little action has been taken by CMS, and as a result, such abuse appears to continue unabated.

Despite industry claims that MA products are a good value for all beneficiaries, significant fissures in MA plan coverage have led to the emergence of a new insurance product aimed at filling those gaps. This product, sometimes called Advantage Plus, is designed to fill in the gaps in MA plans, including high out-of-pocket expenses for vital services such as inpatient hospital care, skilled nursing facility stays, durable medical equipment, and drugs covered under Medicare Part B.

We believe that the existence of these products is a symptom of a more widespread disease afflicting the Medicare Advantage program, and underscores how far too many MA plans impose high cost-sharing while providing inadequate benefits.

Individuals who are dually eligible for Medicare and Medicaid are entitled to a broad range of benefits provided by both programs. Enrollment in Medicare Advantage plans, though, can create problems for dual eligibles such as access to care issues and greater out-of-pocket expenses.

Medicare Advantage special needs plans, or SNPs, are in theory designed to address the needs of duals and other designated populations. Without formal requirements mandating that they provide

care coordination, integration with Medicaid, and targeted case management, often SNPs remain special in name only.

Unfortunately, many duals who were automatically enrolled in SNPs over the last two years have experienced significant problems with accessing care and coordinating coverage and payment with State Medicaid programs.

Other MA plans, notably private fee-for-service plans, are generally ill-suited to address the complex needs of dual eligibles and often cause harm to this vulnerable population. Dual eligibles are targeted by some PFFS plan sponsors and agents without regard to the suitability of such plans, including meaningful comparison with Medicaid benefits already available to them and access to providers who accept both Medicare and Medicaid.

Instead, duals are being targeted and convinced to enroll in PFFS plans based upon extra benefits that agents and plans say will save them money. Once enrolled, however, duals often find that their doctors won't take their plan, and they are charged cost-sharing for services and items they did not previously have to pay for.

We recognize and appreciate that the CHAMP Act would have addressed some of these problems, and we are disappointed it did not become law.

For our specific recommendations on improving the MA program, we refer you to our written testimony and the various documents cited therein. Thank you.

[The statement of David Lipschutz follows:]

**Statement of David Lipschutz, Interim President and CEO,
California Health Advocates, Los Angeles, California**

I. INTRODUCTION

California Health Advocates (CHA) is an independent, non-profit organization dedicated to education and advocacy efforts on behalf of Medicare beneficiaries in California. Separate and apart from the State Health Insurance Program (SHIP), we do this in part by providing support, including technical assistance and training, to the network of California's Health Insurance Counseling and Advocacy Programs (HICAPs) which offer SHIP services in California. CHA also provides statewide technical training and support to social and legal services agencies and other professionals helping Californians with questions about Medicare. Our experience with Medicare is based in large part on our close work with the HICAPs and other consumer assistance programs that are on the front line assisting Medicare beneficiaries.

Of the various options within the Medicare program to access benefits, we recognize that Medicare Advantage (MA) plans can work for some individuals. Other Medicare beneficiaries, however, are often disadvantaged by joining MA plans for a variety of reasons, including restriction of access to providers (including specialists), out-of-pocket expenses (sometimes greater than Original Medicare), and other barriers to care such as utilization management. Payments to MA plan sponsors and corresponding commissions and bonuses paid to agents combine to foster an epidemic of marketing misconduct; all too often, the best plan for the agent is sold rather than the best plan for the beneficiary.

MA plans are, in theory, supposed to "fill in the gaps" of Original Medicare as well as provide additional benefits. Many plans, however, fail to provide protection against out-of-pocket expenses resulting in a new product—the MA gap plan—that is being sold to fill in expensive gaps in MA plans. In addition, certain beneficiaries can be harmed by joining MA plans—in particular, individuals dually eligible for Medicare and Medicaid—as well as other beneficiaries who are faced with unaffordable out-of-pocket expenses as a result of joining such plans.

It is not our purpose to disparage all MA plans, but to call into question the value we are getting out of MA plans collectively, particularly given the amounts MA plan sponsors are paid over and above the costs to Original Medicare of providing care

to similarly-situated beneficiaries. We also question whether informed decision-making is impaired by lack of standardization, and the sheer number of plans combined with countless variations in benefits and cost-sharing that compete for beneficiary attention—particularly PFFS plans—and whether these plans are meeting the needs of all, or even a subset, of beneficiaries.

This written testimony will focus on four areas:

- general issues faced by MA plan enrollees, including plan benefits, cost-sharing, access to providers, trends in retiree coverage, and marketing misconduct;
- new insurance products being sold to fill in the gaps of MA plans;
- the experience of dual eligibles in MA plans; and
- recommendations to address shortcomings of the MA program.

II. GENERAL ISSUES FACED BY MEDICARE ADVANTAGE ENROLLEES

Choosing the appropriate Medicare coverage for an individual's particular circumstances has become tremendously complicated for most Medicare beneficiaries since the enactment of the Medicare Modernization Act of 2003 (MMA). Increased payment to insurance companies has led to a staggering increase in the numbers and types of Medicare Advantage plans. Across the country, Medicare beneficiaries face an unprecedented array of MA products, each with complex benefit variations, and differences in premiums and cost-sharing requirements. These variations tend to confound prospective enrollees, and often obscure the potential for out-of-pocket costs, making it difficult for consumers to compare costs and benefits both between plans and with Original Medicare.

While some individuals do benefit from enrollment in Medicare Advantage plans, it largely depends on an individual's plan and his/her individual needs. Conversely, others are significantly harmed by enrolling in MA plans. Not only do some people who join MA plans lose and have difficulty re-acquiring their Medigap and retiree plans, but the benefits of MA plans can quickly be erased if healthcare needs change, and people need care that is more expensive than under Original Medicare.

MA Plan Benefit Packages and Cost-Sharing

Through analysis of the Medicare Advantage marketplace, along with the collective experience of those who counsel Medicare beneficiaries, it is clear that there are serious deficiencies in the benefit packages of many Medicare private health plans. As discussed in a September 2007 report by California Health Advocates and the Medicare Rights Center, MA plan shortcomings include:

- consumers with chronic illness can unknowingly incur widely varying levels of cost-sharing under different plans;
- many MA plans do not provide a limit on enrollees' annual out-of-pocket expenses for medical services, or they exempt certain services (such as chemotherapy) from such limits; and
- many plans charge the same or higher cost-sharing than Original Medicare for specific, costly services, such as inpatient hospital care, nursing home stays, durable medical equipment and home healthcare.¹

Using the great flexibility afforded by Medicare law and regulations, and under the guise of marketplace "innovation," many plan sponsors design their benefits in such a way that front-loads cost-sharing for the most expensive items, (e.g., hospitalization, skilled nursing facility stays, Part B drugs)—services for which beneficiaries do not have a choice to forego, and are not susceptible to incentives to try other providers (e.g., to see primary care providers rather than specialists) or other treatment options.

Despite these significant shortcomings in plan benefits, many beneficiaries are lured by plans with zero monthly premiums and/or "extra benefits," only to find that once enrolled and in need of services, out-of-pocket expenses can equal or exceed Original Medicare. Cost-sharing for services is too often not made apparent when plans are sold, and those with chronic conditions often face catastrophic costs and are often better off financially by purchasing a Medigap policy.

Example: A HICAP counselor in Southern California who has extensive experience working with individuals with cancer, reports that most MA plans she deals with are charging at least 20% in cost-sharing for chemotherapy and radiation. Enrollees in these plans who receive cancer treatment often have thousands of dollars in monthly out-of-pocket expenses. Most cancer patients in this situation report that

¹ See California Health Advocates and Medicare Rights Center report "Informed Choice: The Case for Standardizing and Simplifying Medicare Private Health Plans (September 2007), available at: <http://www.cahealthadvocates.org/advocacy/2007/09.html>.

*when they signed up with their MA plan they thought the copayments for chemo would be \$35–\$50. Many tell the counselor that they would rather die than leave their families without any money.*²

Many individuals who seek or already have Medigap policies enroll in Medicare Advantage plans because they are led to believe that MA plans either function just as Medigap plans do, or even better (some in fact enroll in MA plans believing them to be actual Medigap policies). Conned by slick marketing, new MA plan enrollees often do not understand that they no longer have the same out-of-pocket spending protections that they had in their Medigap policies, are astonished to find that they can no longer see their regular doctors and are hit with high medical bills. Also, unlike Medigap plans, which cannot change benefits year-to-year and are guaranteed renewable, every year MA plan sponsors can change benefits, cost-sharing and premiums, forcing enrollees to reanalyze their benefits annually.

It is well documented that Medicare Advantage plans are paid more than Original Medicare rates, and, as partial justification, plan sponsors often tout “extra benefits” that are being provided to their enrollees. Many of the same plans that charge the same or higher cost-sharing than Original Medicare downplay those costs but heavily promote additional benefits of lesser value, ranging from eyeglasses, hearing aids, gym membership, to a monthly allotment of over the counter pharmacy supplies. From an individual beneficiary’s standpoint, these “extras” can provide limited value when compared with high out-of-pocket costs and problems accessing providers that accompany many plans. From a broader perspective, luring enrollees with “extra benefits” provided now, given that current payment rates are unsustainable, is setting enrollees up for a bait-and-switch scenario down the road if plan benefits are cut (or even the following year, as plans can fundamentally change their benefits annually).

Access to Providers

Unlike Original Medicare, coordinated care plans limit access to designated provider networks. Some who join MA plans are surprised to learn that providers who they had seen for years are not members of the plan’s network, or refuse to accept the plan’s benefits, forcing them to find new providers or get out of the plan when they are able to do so.

The greatest risk of not being able to find a provider, paradoxically, seems to occur with MA Private Fee-for-Service (PFFS) plans that were created, in part, to allow enrollees to access a wide range of providers. Although enrollees can seek care from any provider willing to accept the plan’s terms and conditions, providers who do not have a contract with the plan can decide whether to continue to accept the plan with each visit or treatment. In many cases, PFFS plan enrollees struggle to find providers willing to accept the plan’s terms and conditions. For example, the California Medical Association reports low participation by its members in PFFS plans, and expresses concern that PFFS plan networks are inadequate, particularly for specialty referrals.³

Example: Ms. P., an 86-year old dual eligible from Central California, was enrolled in a PFFS plan without her knowledge by an insurance agent who knew she was a dual eligible. She was scheduled to have surgery at a local hospital to treat breathing problems and difficulty swallowing food due to a growth in her throat, but the hospital refused to accept the PFFS plan she was enrolled in.

Retiree Coverage

In addition to individuals who give up a Medigap plan in order to enroll in a Medicare Advantage plan, and have difficulty getting their Medigap plan back, some beneficiaries who have pre-existing retiree coverage are often in danger of losing such coverage when they enroll in a Medicare Advantage plan that does not contract with their retiree plan.

Example: Mr. S., a Northern Californian who is 86 years old, had Medicare, Medical (Medicaid) and a retiree plan. After several calls from an insurance agent, Mr. S. gave in and allowed the agent into his home. Although the agent was aware that Mr. S. had retiree coverage, she pressured him to enroll in an MA PFFS plan anyway. As a result, he lost his retiree coverage. The local HICAP program is working to try to help him get his retiree plan back.

²Also see an article in California Health Advocates’ August 2006 online newsletter re: chemo copays for cancer patients and the trend in MA plans towards charging full Part B cost-sharing vs. flat copays at: <http://www.cahealthadvocates.org/newsletter/2006/08/cancer.html>.

³Correspondence between California Health Advocates and the California Medical Association, February 2008.

In contrast with retiree plans that do not coordinate with Medicare Advantage, other employers are increasingly looking to push their retirees into Medicare Advantage plans, leading to access to care issues, as well as strains on the financial viability of the Medicare program for all beneficiaries, not just those in MA plans. There is a growing trend of State and local governments, organizations and corporations attempting to save money by shifting their healthcare costs to the Federal government and enrolling retirees in Medicare Advantage products, particularly Private Fee-for-Service (PFFS) plans.⁴ This trend exacerbates the strain on Medicare's finances already imposed by Medicare Advantage overpayments. The same problems encountered by other PFFS enrollees also confront retirees. Although plan sponsors market PFFS products as "nationwide" because they are not required to use a network, David Fillman of AFSCME notes that this claim is "false"; PFFS plans "limit access to care and choice because significant numbers of doctors and hospitals have refused to accept [the patients enrolled in these plans], especially out-of-state."⁵

Example: The Center for Medicare Advocacy reports recently hearing from a Michigan retiree who is now living in Orlando, Florida, and can't find a doctor or hospital that is willing to accept the PFFS plan his former employer forced him into. He reports that his Blue Cross Blue Shield plan is working on the problem, but in the meantime he can't go to a doctor or hospital.

Marketing Misconduct

Consumer advocates, State insurance regulators, Congress and the media have all focused attention on appalling abuses surrounding the sale of Medicare Advantage plans over the last two years that have resulted in substantial harm to the victims of such abuse and financial gain to insurance companies and agents.⁶ While much attention has been paid to these abuses, in our view, far too little action has been taken by CMS, which, under the MMA, retains the sole jurisdiction over almost all regulatory issues concerning MA plans. Unfortunately, SHIP programs across the country report that marketing misconduct continues unabated.

We refer the Subcommittee to the resources cited above which address marketing misconduct surrounding the sale of MA plans, including incentives pushing such activity. The following, though, serves as a typical example of marketing misconduct, this one impacting a member of the HICAP family in California earlier this month. Although this example is lengthy, it is illustrative in that it includes a number of the common lies, deceptions and distortions that agents still widely use to con people into joining Medicare Advantage plans.

Example: Ms. T., a dual eligible with limited English proficiency living in California's Central Valley, received a call from an insurance agent claiming to be from the "health department" and said she wanted to come by and "check up" on her. Ms. T. asked her daughter, who works for a local HICAP program, to be present when the agent visited her home in early February 2008. The agent arrived wearing a badge that appeared very similar to a Medicare card, with the agent's name handwritten on it, and declared that she was "from Medicare." The agent lied that she was not an agent, and was not there to sell anything, but simply wanted to go over Medicare issues. The agent explained that Ms. T. has Medicare Parts A, B, and D, so now she needed to enroll in Part C. She stated that Part C "works with Medicare together" and she would have no copays. She stated that when "you go to the doctor, you show your Medicare and Medi-Cal card, but when you go to a doctor that doesn't accept Medi-Cal, you would show your Medicare Advantage card—all 3 cards work together." She added that "you do know that Medicare and Medi-Cal won't cover nursing homes, so you need to enroll in Part C right away—you shouldn't be long, you shouldn't be without coverage." When the agent pulled out an MA application, Ms. T.'s daughter declined, but asked the agent to leave information. The agent refused to leave marketing material, stating that she only had one copy, but left her business card, indicating that she was indeed a broker selling MA products. Since Ms. T.'s daughter works for a local HICAP, she realized that just about everything said by the agent was a lie or deception at best, and prevented her mother's enrollment in

⁴See, e.g., "Medicare Trend Raises Eyebrows" by Ricardo Alonso-Zaldivar, *Los Angeles Times*, 2/11/08.

⁵Testimony of David Fillman, AFSCME, before the Senate Finance Committee on 1/30/08, available at: <http://finance.senate.gov/hearings/testimony/2008test/013008dftest.pdf>.

⁶See, e.g. issue briefs written by California Health Advocates and the Medicare Rights Center entitled "After the Gold Rush: The Marketing of Medicare Advantage and Part D Plans" (January 2007) and "The Reluctant Regulator: Centers for Medicare and Medicaid Services' Response to Marketing Misconduct by Medicare Advantage Plans" (July 2007); also see California Health Advocates' testimony before this Subcommittee on May 22, 2007 and before the House Energy & Commerce Subcommittee on Oversight & Investigations on June 26, 2007. All of these documents are available at: <http://www.cahealthadvocates.org/advocacy/index.html>.

this plan. The vast majority of Medicare beneficiaries do not have such accessible help when targeted by unscrupulous agents.

Despite the claims of the insurance industry, this is not a matter of “rogue agents” or a “few bad apples”—we are convinced that the payment incentives to plans, and, in turn, the commissions and bonuses paid to agents, drive this type of abuse. While states retain jurisdiction over agents selling Medicare plans, they lack authority to punish the plans for a range of misbehavior, including actions performed by agents selling their products. While a few MA plans have received nominal fines, enrollment suspensions and other more severe punitive measures are rarely meted out by CMS. As discussed below, in our experience, the most severe and prevalent marketing abuses continue to concern the sale of Private Fee-for-Service plans to dual eligibles.

III. MEDICARE ADVANTAGE “GAP” PRODUCTS

The insurance industry and CMS insist that Medicare Advantage products are a good value for all beneficiaries, in terms of “extra” benefits offered and out-of-pocket savings when compared with the Original Medicare program. Despite these assurances, however, significant fissures in MA plans have led to the emergence of a new insurance product aimed at “filling” those gaps. This product, sometimes called “Advantage Plus”, is being marketed by plan sponsors to insurance agents as a “wrap-around plan” that is “designed to fill in the gaps in Medicare Advantage Plans.”⁷

These limited-benefit plans bundle a collection of insurance products, such as hospital indemnity plans and other piecemeal coverage, and pay cash benefits directly to enrollees of MA plans to cover out-of-pocket costs imposed by their MA plan. They are designed specifically to address high out-of-pocket expenses charged by many MA plans for vital services such as inpatient hospital care, skilled nursing facility stays, durable medical equipment and cancer/chemotherapy drugs covered under Medicare Part B.

Companies offering these products encourage insurance agents to sell these “gap” plans alongside Medicare Advantage products. For example, one flyer directed towards agents boasts: *“If selling Medicare Advantage Plans, be sure to check out our Wrap Around product section. Easily add an additional 50% in commissions to each Medicare Advantage Sale. Plan can be sold all year long!”* Anecdotally, we have heard of agents encouraging MA enrollees who get a Part B premium rebate through their plan to apply those savings towards purchasing one of these gap products.

The sale and promotion of these products exacerbates the confusion in the Medicare marketplace generated by enormous numbers of MA and Part D plans with multiple and complex plan designs. Further, we believe that the existence of these plans is a symptom of a more widespread disease afflicting the Medicare Advantage program, and underscores how far too many MA plans impose high cost-sharing while providing inadequate benefits. Part of the promise of allowing private insurance companies to offer plans within the Medicare program was that they could provide better benefits, more efficiently, for less money to both beneficiaries and the Medicare program. These gap products, though, that are sold to fill in gaps in coverage that MA plans are failing to fill themselves, starkly highlight the failures of the MA program to achieve these goals.

IV. DUAL ELIGIBLES and MEDICARE ADVANTAGE PLANS

Individuals who are dually eligible for Medicare and Medicaid are entitled to a broad range of benefits provided by both programs. This population, many of whom have significant and complex health needs and generally a lower level of health literacy, rely on overlapping coverage and payment through the Original Medicare program as primary payer and Medicaid as additional coverage. Many MA plans find dual eligibles to be attractive targets due to their right to enroll in and disenroll from plans on a monthly basis, allowing plans to “poach” enrollees from one another, and also because capitated payments to plans are generally higher for dual eligibles.

Enrollment into a Medicare Advantage plan, though, can create problems for dual eligibles not encountered in the Original Medicare program, such as access to care (due to problems accessing providers and utilization management techniques) and greater out-of-pocket expenses. The issue of whether a State Medicaid program is obligated to pay the Medicare cost-sharing for dual eligibles enrolled in MA plans is a complicated one, and includes factors such as a “dual eligible’s coverage cat-

⁷ See a recent issue brief on this topic written by California Health Advocates entitled “There’s a Hole in the Bucket: New “Gap” Product Being Sold to Fill-in Medicare Advantage Deficiencies” (November 2007), available at: <http://www.cahealthadvocates.org/advocacy/2007/11.html>.

egory, the type of cost-sharing, the options elected by the State, and payment limitations specified in the State Plan.”⁸ In short, practically speaking, it appears that many States do not pay MA cost-sharing for duals in their State, and, as a result, dual eligibles are often charged these amounts. In addition to MA cost-sharing, some duals have to pay premiums for MA plans for coverage that is no different and sometimes worse than under Medicaid.

Certain MA plans—Special Needs Plans (SNPs), are—in theory—designed to address the needs of dual eligibles, although it is questionable how well many SNPs perform in this regard. Other MA plans, notably Private Fee-for-Service (PFFS) plans, are generally ill-suited to address the complex needs of dual eligibles, and often cause significant harm to this vulnerable population.

Special Needs Plans (SNPs)

The Medicare Modernization Act (MMA) authorized Medicare Advantage Special Needs Plans (SNPs) that can be designed to provide coverage for certain designated populations: dual eligibles; individuals who are institutionalized; and individuals with chronic and disabling conditions. Since 2006, enrollment in SNPs has increased exponentially, however many dual eligibles—most of whom did not seek out a SNP on their own but were automatically enrolled into one—have experienced significant problems with accessing care and coordinating coverage and payment with State Medicaid programs.

While SNPs present the opportunity for better care coordination, integration and targeted care management, there are no formal requirements set out in law, regulation or CMS guidance that SNPs actually deliver these goals. In the words of one advocate with significant experience assisting dual eligible clients who encounter problems with their SNPs, “absent minimum standards for meeting the special needs of the populations they serve, labeling these plans as specially designed to do so is misleading.”⁹

Private Fee-for-Service (PFFS) Plans

While SNPs are designed to address the needs of dual eligibles (at least in theory), other Medicare Advantage plans enroll dual eligibles and even seek them out, even though enrollment in many plans appears to offer little tangible benefit, if any, and often leads to significant problems. Over the last two years, we continue to see a disturbing trend of PFFS plan sponsors and their contracting agents marketing PFFS plans to dual eligibles. In many cases, dual eligibles have been left worse off due to access to care issues (including loss of access to providers) and increased out-of-pocket costs.¹⁰

In our experience, some of the worst and most widespread marketing violations have involved dual eligibles who are sold PFFS plans. Information about the suitability of MA plans for dual eligibles, including meaningful comparisons with Medicaid benefits already available to them, is not made available by the plans or is misleading, and, at best, glossed over during sales pitches.

Example: Mr. C., age 74, is a California dual eligible who is very ill and dependent on oxygen. He was visited by an insurance agent recently who pushed him to enroll in an MA PFFS plan. The agent touted it as a plan “just for people on Medi-Cal.” As a result of his enrollment, Mr. C. is now being billed for services he did not previously have to pay for, including about \$4,000 from a durable medical equipment provider who was not paid by the plan. The local HICAP is assisting him with his enrollment and billing issues.

Dual eligibles are being targeted and convinced to enroll in PFFS plans based upon “extra” benefits that agents and plans say will save them money. Duals are often enticed by \$20 over the counter benefits, and “extra” hearing, vision and dental coverage, without regard to individual states’ actual Medicaid benefits that they might already be entitled to.

⁸ June 11, 2007 Memorandum from CMS, Center for Medicaid and State Operations, Disabled and Elderly Health Programs Group to All Associate Regional Administrators, Division of Medicaid and Children’s Health re: Medicaid Obligations for Cost-Sharing in Medicare Part C Plans; also see Center for Medicare Advocacy’s May 31, 2007 Weekly Alert entitled “Medicare Cost-Sharing in Medicare Advantage Plans: Who Pays for Dual Eligibles?” at: http://www.medicareadvocacy.org/AlertPDFs/2007/07_05.31.MAMcaidCostShare.pdf.

⁹ Alissa E. Halperin, Managing Attorney, Pennsylvania Health Law Project, author of a paper for the Center for Medicare Advocacy entitled “Medicare Advantage Special Needs Plans: A Beneficiary Perspective” (October 2007); also see, generally, Center for Medicare Advocacy’s Special Needs Plan Conference materials (October 2007), available at: <http://www.medicareadvocacy.org/SNP%20Conference/Home.htm>.

¹⁰ See, e.g., CHA’s prior testimony before this Subcommittee on May 22, 2007 re: PFFS plans, available at: http://www.cahealthadvocates.org/advocacy/2007/CHA_WaysMeans_testimony_0522.html.

Once enrolled, however, duals often find that their doctors won't take their PFFS plan. If their primary doctor does take the plan many still find that they are charged for doctors' visit copays, wheelchairs, walkers and other services and items they did not previously have to pay for. A large portion of duals encounter difficulty finding specialists who will agree to accept their plan. When HICAP programs try to help dual eligibles get out of plans that are not appropriate for them and untangle resulting complex billing issues, some beneficiaries are subject to harassing calls from agents upset that they are losing out on their commissions.

At least one PFFS plan sponsor acknowledges that this plan type is not appropriate for dual eligibles. During a Congressional hearing wherein his company was criticized for the conduct of an agent selling his PFFS plan to dual eligibles, Coventry Vice President Francis Soistman admitted that " . . . PFFS plans may not be suitable for dual eligibles."¹¹

Other plans, however, hold themselves out as specially catering to duals—notably WellCare Duet PFFS plans. When asked about the appropriateness of PFFS plans targeting dual eligibles for enrollment, a CMS official replied at a hearing before this Subcommittee that Medicare Advantage "is a market-based program and dual-eligibles, like everyone else, have the option of choosing how they wish to obtain services and where they wish to be enrolled."¹²

V. RECOMMENDATIONS

California Health Advocates, as well as a number of other beneficiary advocacy groups, has offered several recommendations for curing some of the current problems faced by Medicare Advantage enrollees.¹³ We recognize—and appreciate—that the Children's Health and Medicare Protection (CHAMP) Act of 2007, passed by the House last August, addressed a number of these issues, and we are disappointed that it did not become law. Our recommendations range from broad changes to the structure and financing of Medicare Advantage, to specific proposals that can be implemented by CMS as the Federal regulator of these plans. In short, these recommendations include:

- Create standard benefit packages for Medicare Advantage and Part D plans, including:
 - Establish no more than two annual limits for out-of-pocket costs
 - Prohibit separate cost-sharing for individual Part B services
 - Require that MA plans charge no more cost-sharing for services than what is charged under Original Medicare
 - Limit the number of plans offered in a given geographic area
- Apply the standardization and simplification requirements of the National Association of Insurance Regulators (NAIC) Medigap Model Act and Regulation to all Medicare Advantage (and Part D) plans
 - These requirements should include loss ratio standards, guaranteed renewability requirements, suitability requirements and other consumer protections
 - Rescind the statutory preemption that prevents states from enforcing State laws on consumer protections and the marketing of insurance products
 - Neutralize payment between Original Medicare and the MA program (see, e.g., recommendations from MedPAC) and use the current excess payments to strengthen access to benefits in other areas of Medicare, such as expanding eligibility for the Medicare Savings Programs and the Part D Low-Income Subsidy
 - Ban the sale of PFFS and other MA products to dual eligibles unless plans can prove they offer meaningfully better and more comprehensive benefits than those available through State Medicaid programs, and that enrollees will not face diminished access to providers and/or new out-of-pocket expenses
- Authorize NAIC to develop nationwide marketing guidelines, including:
 - Provisions that hold plans more accountable for the actions of agents selling their plan

¹¹Testimony of Francis S. Soistman, Jr., Executive Vice President, Coventry Health Care, Inc., before House Energy & Commerce Subcommittee on Oversight & Investigations, June 2007, available at: http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.062607.Soistman-testimony.pdf.

¹²Testimony of Abby Block, Director of Division of Beneficiary Choices, CMS, May 22nd, 2007.

¹³See, e.g., documents cited in footnotes 1 and 6, *infra*, as well as CHA's testimony before the National Association of Insurance Commissioners (NAIC) Senior Issues Task Force—Medicare Private Plans Subgroup, Public Hearing on Regulation of Medicare Private Plans (September 11, 2007), available on the NAIC website.

- Prohibit plans from offering differential commissions based on what type of plan is selected by the enrollee
- Prohibit agents from selling unrelated products
- Develop more comprehensive disclosure documents with clear explanations about how certain choices can impact access to providers and other types of insurance coverage (e.g., retiree, Medigap, Medicaid)
- Exclude plan sponsors culpable of egregious marketing and other violations from participating in the Medicare program for at least two years (similar to rules that apply to certain providers)

VI. CONCLUSION

While some Medicare Advantage plans do provide value for enrollees, we need to question the value provided by all MA plans—considering the sheer number of plans, variation in benefits and cost-sharing and the fact that the majority of Medicare beneficiaries in the Original Medicare program are subsidizing the extra payments meant to enrich the minority of beneficiaries enrolled in MA plans. Medicare Advantage is not the panacea for perceived shortcomings of Original Medicare, and, in many cases, can be to the detriment of enrollees, particularly the most vulnerable among us. At a time when MA plans are overpaid but many are providing inadequate coverage, Congress should carefully scrutinize the MA program that threatens the stability and integrity of the entire Medicare program.

Thank you for the opportunity to provide these comments.

Chairman STARK. Thank you very much.
Dr. Lyons?

STATEMENT OF DANIEL C. LYONS, M.D., SENIOR VICE PRESIDENT, GOVERNMENT PROGRAMS, INDEPENDENCE BLUE CROSS, PHILADELPHIA, PENNSYLVANIA

Dr. LYONS. Thank you, Mr. Chairman, Ranking Member Camp, and members of the committee. My name is Daniel Lyons, M.D., and I am senior vice president of government programs for Independence Blue Cross, and I do appreciate the opportunity to testify about the Medicare Advantage program.

Independence Blue Cross is strongly committed to the long-term success of the Medicare Advantage program. We are proud to sponsor plans that offer many services and innovations that are not included in the Medicare fee-for-service program. Approximately 240,000 Medicare beneficiaries in Philadelphia and southeastern Pennsylvania are enrolled in the plans we offer.

Our Medicare Advantage plans serve a critical role in providing comprehensive, coordinated benefits for many seniors and disabled Americans. The fundamental difference between Medicare Advantage plans and the Medicare fee-for-service program is that our private plans have established an infrastructure for improving health-care quality on an ongoing basis.

At Independence Blue Cross, our plans focus on identifying members with important clinical needs, including those not receiving preventive care, those who are frail, and those with chronic illness. Because Medicare Advantage plans do have an infrastructure to coordinate and improve the care for these members, we have a proven track record of making a positive difference in the lives of Medicare beneficiaries.

Many Medicare beneficiaries do suffer from multiple chronic conditions such as diabetes, heart disease, cancer, asthma, depression.

One recent study suggested that over 80 percent of beneficiaries have at least one of these chronic conditions.

Medicare Advantage plans are playing a leadership role in developing strategies and programs to improve patient care for beneficiaries with multiple chronic conditions. We are focused not only on ensuring that patients with chronic conditions live longer, but we are also helping them live healthier lives with fewer symptoms so they can fully participate in the activities they enjoy.

Our Medicare Advantage members benefit from a variety of programs we have developed over the years to improve their care, including the promotion of prevention and wellness. For example, our Connections Health Management program is designed to help our Medicare Advantage members by making them more informed about their health conditions, assisting them in making difficult treatment decisions, helping them and their physicians improve the management of chronic conditions, and assisting members, their physicians, and their caregivers with the coordination of care.

Through this program, we use sophisticated predictive modeling tools to identify those members who are at highest risk for future health events, and identify specific gaps in care and to fill those gaps. Specially trained health coaches, typically RNs, are available 24/7/365. They do telephonic outreach to these members to address their care gaps, help them understand their physician's treatment plan, and improve self-management of their chronic conditions.

The results of this program are very impressive. In 2007, our member satisfaction survey showed that 94 percent of members were satisfied with their health coach assistance, 90 percent were satisfied with their overall program experience, and 94 percent said they would recommend the program to other seniors.

Moreover, 97 percent of members with chronic conditions indicated they were able to follow their health coach's advice, nearly 80 percent reported an improved ability to communicate with their physician, and nearly 60 percent said that speaking with a health coach actually improved the quality of care they received from their healthcare provider.

Medicare Advantage members have also enthusiastically embraced our wellness programs. More than 9,000 seniors are enrolled in fitness programs we have designed to encourage and promote healthy, active lifestyles. Almost 60 percent of these seniors complete the program target of 120 visits a year, which is twice the rate of non-Medicare members.

Another problem we implemented for Medicare Advantage members is our physician home visit program. Under this program, a physician conducts a proactive home visit to assess members who are homebound and then provides follow-up care as needed, and also coordinates care with the member's primary care and specialty physicians. This program is designed to improve the control of chronic illnesses and reduce the use of emergency services for medically frail members.

We also work on an ongoing basis to provide Medicare Advantage members with access to care coordination throughout their healthcare experience. For example, when a member is scheduled for an elective admission such as a total knee replacement, we reach out, identify their anticipated post-hospital needs, coordinate with their

surgeon, begin to make arrangements for post-hospital care such as rehabilitation, long before the member ever goes to the hospital.

This sort of care coordination, like our wellness disease management programs, are not currently available in traditional Medicare, and not readily created without considerable planning and investment. In fact, when you consider the array of health infrastructure investments and improvements we have implemented over the past decade—credentialing a system of quality checks on physicians and providers that includes checks on medical records and office adequacy, physician performance monitoring and quality incentives, coverage and promotion of preventive medicine, fitness, smoking cessation, weight management and related programs, health education, nurse counseling, disease condition management, medication and therapy management, case management, home visits, et cetera—you can begin to understand the extent of the planning and investment required to bring these kinds of advancements to the entire Medicare program.

Thank you for this opportunity to testify on the Medicare Advantage program. We appreciate the opportunity, and urge the committee to continue to support adequate funding for the system of competition, choice, and innovation that is delivering savings and value to nearly nine million Medicare Advantage members.

[The statement of Daniel C. Lyons follows:]

**Testimony on
The Medicare Advantage Program**

By

**Daniel C. Lyons, M.D.
Senior Vice President, Government Programs
Independence Blue Cross**

**Before the
U.S. House Committee on Ways and Means
Subcommittee on Health**

February 28, 2008

I. Introduction

Mr. Chairman, Ranking Member Camp, and members of the subcommittee, my name is Daniel Lyons. I am Senior Vice President of Government Programs for Independence Blue Cross, and I appreciate this opportunity to testify about the Medicare Advantage program and its role in providing Medicare beneficiaries with options for high quality, affordable, comprehensive health coverage.

Independence Blue Cross is a non-profit health insurer that serves 3.4 million members, approximately 240,000 of which are Medicare beneficiaries; and is part of the national network of 39 Blue Cross and Blue Shield plans that insure approximately one out of every three Americans. Most of our members are in the greater Philadelphia region, and we are both the region's most preferred health insurer as well as the insurer of last resort. We offer a range of coverage options to Medicare beneficiaries, including HMO plans, point-of-service (POS) plans, PPO plans, Medicare Part D coverage, and supplemental coverage.

Independence Blue Cross is strongly committed to the long-term success of the Medicare Advantage program. We are proud to sponsor plans that offer many services and innovations that are not included in the Medicare fee-for-service (FFS) program. Our Medicare Advantage plans serve a critical role in providing comprehensive, coordinated benefits for many seniors and disabled Americans – including low-income beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare FFS program.

My testimony today will focus on three broad areas:

- the conceptual rationale for why Medicare Advantage plans add value over the Medicare FFS program;
- advances in care coordination and disease management that are significantly improving patient care for beneficiaries enrolled in Medicare Advantage plans; and

- the value the Medicare Advantage program offers beneficiaries, particularly those who need assistance managing their multiple chronic conditions.

II. Why Medicare Advantage Adds Value Not Found in Medicare FFS

The fundamental difference between Medicare Advantage plans and the Medicare FFS program is that the former have established an infrastructure for improving health care quality on an ongoing basis. This is critical, because it is well documented that we have significant shortcomings in the quality of health care under our current system in general and the Medicare program in particular. Over the past decade, the Institute of Medicine (IOM) has focused the nation's attention on the critical need to improve health care quality and patient safety, coordinate chronic care, and support evidence-based medicine. A 1999 IOM report¹ found that medical errors could result in as many as 98,000 deaths annually, and a more recent IOM report acknowledged the fragmented nature of care delivery in the Medicare FFS program, which does "little to encourage coordinated, preventive, and primary care that could save money and produce better health outcomes."²

Other studies have documented specific shortfalls in quality. For example, a study conducted by RAND³ found that patients received only 55 percent of recommended care for their medical conditions, and a study by the Medicare Payment Advisory Commission (MedPAC)⁴ showed that only two-thirds of Medicare beneficiaries received necessary care for 20 of 32 indicators. The MedPAC report concluded that "care coordination is more difficult to do in the FFS program because it requires managing patients across settings and over time, neither of which is supported by current payment methods or organizational structure." Additional studies indicate that Americans frequently receive inappropriate care in a variety of settings and for many different medical procedures, tests, and treatments. Such inappropriate care includes the overuse, underuse, or misuse of medical services.

¹ "To Err is Human," Institute of Medicine, 1999

² IOM Report: "Rewarding Provider Performance: Aligning Incentives in Medicare," IOM, 9/21/06

³ "The Quality of Health Care Delivered to Adults in the United States," Elizabeth A. McGlynn, RAND, June 25, 2003

⁴ MedPAC, Report to Congress: Increasing the Value of Medicare, June 2006

Medicare Advantage plans focus on identifying members with important clinical needs, including those not receiving preventive care, those that are frail, and those with chronic illness. Because Medicare Advantage plans have an infrastructure to coordinate and improve care for these members, there is a proven track record of making a positive difference in the lives of Medicare beneficiaries. The 2007 NCQA State of Quality Report⁵ documents significant improvements over time in the quality of care for Medicare beneficiaries enrolled in Medicare Advantage plans, and a good example of this is the improvement in care for cardiac patients. In 2006, approximately 94 percent of Medicare beneficiaries in Medicare Advantage plans received a beta-blocker upon discharge from a hospital after having a heart attack. Ten years earlier that number was close to 60 percent. Beta blockers have been proven to save lives if given after a heart attack, so this significant increase in the use of beta blockers is saving lives and the favorable trend for Medicare Advantage members is not matched in the FFS program.

III. Advances in Care Coordination and Disease Management

The participation of private health insurance plans in Medicare has enabled millions of seniors and disabled persons to benefit from chronic care initiatives and other innovations that are improving their health care and enhancing their overall quality of life. Many Medicare beneficiaries suffer from multiple chronic conditions – such as diabetes, heart disease, cancer, asthma, and depression – and one study suggests that over 80 percent of Medicare beneficiaries have at least one chronic condition.⁶ Medicare Advantage plans meet a critical need by offering care coordination and management for diseases that commonly afflict the elderly.

Health insurance plans are playing a leadership role in developing strategies and programs to improve patient care for persons with chronic conditions. We are focused not only on ensuring that patients with chronic conditions live longer – but we also are helping them live healthier lives, with fewer symptoms, so they can fully participate in the activities they enjoy. This requires a strong emphasis on preventive care, personal responsibility for healthy lifestyles, and

⁵ The State Of Health Care Quality 2007, NCQA, September 2007

⁶ Wolff, Starfield and Anderson, "Prevalence, Expenditures and Complications of Multiple Chronic Conditions in the Elderly," *Archives of Internal Medicine*, November 11, 2002

early intervention to promote care strategies that are effective in improving the patient's quality of life.

Health plans have a strong track record of encouraging prevention and evidence-based care for individuals with chronic conditions. We also are working on an ongoing basis to continue to develop new tools and greater expertise to help physicians customize care strategies to meet the unique needs and circumstances of individual patients. Building upon the success of early innovations in disease management, we are taking personalized service to a new level through a new generation of chronic care initiatives. Recent publications by America's Health Insurance Plans (AHIP)⁷ and the Blue Cross Blue Shield Association (BCBSA)⁸ document numerous examples of health plan programs that provide the frail elderly and others with chronic conditions the care they need. These efforts reflect the following interconnected trends:

- First, plans are using increasingly sophisticated data mining techniques, such as informatics and predictive modeling, to identify high risk members and members with documented gaps in care. The most recent advances in the use of information technology include moving toward personal health records (PHRs) for health plan enrollees – to improve the delivery of care, enhance health care quality, and increase productivity. In November 2006, the Board of Directors of our industry association, AHIP, endorsed a set of recommendations calling for the industry to implement steps to standardize health plan-based PHRs. These recommendations, developed in partnership with BCBSA, will facilitate both information sharing between consumers and caregivers, and portability when a consumer changes health plans.
- Second, plans are proactively reaching out to members who are at high risk, and to their physicians, to offer information, guidance and support on closing gaps in care, increasing the use of preventive care, and improving self-management and provider management of chronic illnesses.

⁷ AHIP, *Innovations in Chronic Care*, March 2007

⁸ Blue Cross Blue Shield Association, *Medicare Advantage: Improving Care Through Prevention, Coordination, and Management*, February, 2007

- Third, plans are offering health coaching to change patient behavior. Through the use of nurses and other health professionals who are trained to serve as health coaches, we are helping health plan enrollees to better understand their treatment options to make more informed health care decisions; to make lifestyle changes to improve their health; to understand and follow their doctors' treatment plans; and to address other health and social service needs.
- Fourth, plans are recognizing that patients are well served by a comprehensive strategy that addresses the needs of each person as a whole, rather than a narrow approach that targets individual diseases. Accordingly, we are using nurse case managers to identify barriers to effective care (including financial, transportation, or social support issues, and a lack of integration between health care providers) and are helping individuals overcome these barriers and get their care better coordinated.
- Finally, plans are placing a greater focus on prevention, wellness and the continuum of health care services that people need throughout their lives. By providing a full spectrum of services – ranging from wellness and prevention to acute, chronic, and end-of-life care – we are improving health outcomes and addressing the unique needs and circumstances of each individual patient.

The effectiveness of these initiatives was highlighted in a 2007 report⁸ by the California Association of Physician Groups (CAPG), which states: "It is the experience of more than 150 physician groups in California and the 59,000 physicians who are part of these groups that they are able to provide better health care to their patients who are in Medicare Advantage plans than those in traditional Medicare." While discussing the specialized services that are needed for patients with chronic conditions, the report states that "these care management services are possible only in the context of the MA program and are virtually non-existent in traditional Medicare."

⁸ The Experience of California Physicians in the Medicare Advantage and Traditional Medicare Programs, Executive Summary, California Association of Physician Groups, June 2007

Allow me to provide some examples of the types of programs that are in place at Independence Blue Cross. Our Medicare Advantage members benefit from a variety of programs aimed at improving their care, including the promotion of prevention and wellness. Here are some specifics of these programs:

Our ConnectionsSM Health Management program is designed to help our Medicare Advantage members by making them more informed about their health conditions, assisting them in making difficult treatment decisions, helping them and their physicians improve the management of chronic conditions, and assisting members and their physicians with the coordination of care.

- This program is available to all 165,000 of our Medicare Advantage members, and only about 2 percent of these beneficiaries opt out of the program.
- Approximately 70,000 of these members have one or more of five common chronic illnesses: coronary heart disease, congestive heart failure, diabetes, chronic obstructive pulmonary disease, or asthma. An additional 2,600 members have one of 16 less common chronic illnesses such as Parkinson's Disease, rheumatoid arthritis, or seizure disorders; and 500 have end stage renal disease.
- Using sophisticated predictive modeling tools, we identify those members who are at highest risk for future health care events, and identify specific gaps in care. Examples of these gaps in care would include such events as members with congestive heart failure not on appropriate medication therapy, elevated cholesterol levels in members with heart disease, lack of appropriate monitoring of blood sugars in diabetics or blood sugar levels that are too high, or the lack of a prescription for a medication included in evidence-based recommendations for a particular disease or condition.
- Specially trained health coaches, who are typically RNs and are available 24/7, 365 days a year, do telephonic outreach to these members to address their care gaps, and to help them understand their physician's treatment plan and improve self-management of their chronic conditions.

- These health coaches can also provide shared decision-making support for any member facing a number of specific treatment decisions, such as the treatment of low back pain, or the treatment of prostate or breast cancer.
- The physicians caring for these patients receive a comprehensive registry, the SMARTTM Registry, that lists each of their patients with a chronic illness, specific gaps in care that exist for each patient, and how that practice's overall performance in the management of chronic disease compares to their peers. In addition, patient-specific "action" sheets are provided to the physician to place in each patient's chart.
- The results of this program are impressive:
 - In our 2007 member satisfaction survey, we found that 94 percent of members were satisfied with their Health Coach assistance and 90 percent were satisfied with their overall program experience. Ninety-four percent said they would recommend the program to others.
 - Moreover, 97 percent of members with chronic conditions indicated that they were able to follow their Health Coach's guidance and nearly 80 percent of these members reported an improved ability to communicate with their health care provider as a result of speaking with a Health Coach. Sixty percent said that speaking with a Health Coach affected the quality of care they received from their health care provider.
 - Through prevention of complications and relapses of chronic illness, there was a 10 to 15 percent reduction in the use of inpatient hospital days and of professional services such as office visits.
 - Overall medical cost trends came down 1.5 to 2 percent in year one of the program and 3 to 5 percent for year two of the program.
 - There have also been increases in specific quality indicators related to each of the chronic conditions.

Our Medicare Advantage members have enthusiastically embraced wellness programs. At Independence Blue Cross, during 2006 over 9,000 seniors enrolled in our fitness programs, designed to encourage and promote healthy, active lifestyles. Almost 60 percent of these seniors completed the program target of 120 visits per year, double the rate of our non-Medicare members who enrolled in the program.

Another program we have implemented for Medicare Advantage members is our Physician Home Visit program. This program is targeted at keeping home-bound members healthy. These members are some of the most medically frail members we have, but their underlying condition is often a barrier to them keeping appointments for physician visits, and in the absence of timely care their condition deteriorates. Home visits by a physician are an ideal solution, but no longer available to most of our members. Therefore, we identified a group of physicians willing to make "house calls." Our program provides for a physician to conduct a proactive home visit to assess members, and then the physician provides follow up care as needed. This physician also coordinates care with the member's primary care physician and other specialty physicians as needed. While our program only began last year, other health plans have implemented similar programs and seen high levels of member satisfaction, improved control of chronic illnesses, and reduced use of emergency services.

Finally, on an ongoing basis we provide Medicare Advantage members with access to care coordination throughout their health care experience. Examples of this are proactive coordination of post-hospitalization care needs. When a member is scheduled for an elective admission, such as a total knee replacement, we reach out to the member to identify their anticipated post-hospital needs, coordinate with their surgeon, and begin to make arrangements for post-hospital care, such as rehabilitation, before the member actually goes to the hospital. In selected cases, we have identified important pre-operative risks that needed to be resolved before surgery. Upon discharge, we follow up with 48 hours of discharge to make sure the member understands their post-hospital treatment plan and that all necessary care has, in fact, been put in place.

Our programs are carefully selected to meet the local needs of our members, but are similar to those of other health plans. In fact, most Medicare Advantage plans offer these types of valuable services to their members. The latest generation of innovations builds upon the lessons health insurance plans have learned over the past decade about outreach strategies that work, about incentives that encourage healthy lifestyle changes and the use of effective treatments, and about how to track patients' progress in obtaining recommended care. While traditional population-based approaches have offered educational materials and other services to individuals identified as having certain conditions, a growing number of plans are now implementing multi-dimensional programs that offer customized care to reflect the severity of each individual's illness.

For example, an asthma patient who has experienced multiple trips to the emergency room would receive specialized attention, including regular phone consultations with a nurse case manager. Another asthma patient who also suffers from depression would be paired with nurses and social workers who could provide a more intensive level of case management. Yet another asthma patient who takes his medications regularly and has not had any recent emergencies would receive quarterly newsletters and access to a toll-free hotline so he can contact a nurse with questions or concerns.

Through all of these activities, health insurance plans are working on a daily basis to add value to the U.S. health care system and improve patient care for Americans – including Medicare beneficiaries – who have chronic conditions. By promoting healthy behaviors and preventing unnecessary complications and health emergencies, our innovative tools and programs are promoting the best possible use of our nation's health care dollars and enhancing the health, well-being, and productivity of the American people.

IV. The Value of the Medicare Advantage Program

The creation of the Medicare Advantage program, as renamed and revitalized under the Medicare Modernization Act of 2003 (MMA), has provided valuable opportunities for seniors and disabled Americans to benefit from the innovations developed and implemented by private

health insurance plans. Nearly 9 million beneficiaries currently receive high quality coverage through the Medicare Advantage program.

Medicare Advantage plans offer a different approach to health care than beneficiaries experience under the Medicare FFS program. Instead of focusing almost exclusively on treating beneficiaries when they are sick or injured, we also place a strong emphasis on preventive health care services that help to keep beneficiaries healthy, detect diseases at an early stage, and work to avoid preventable illnesses.

The chronic care initiatives outlined in the previous section have special significance for our nation's Medicare beneficiaries. Independence Blue Cross and other Medicare Advantage plans have been at the forefront in offering care coordination and management services that are not available in the Medicare FFS program. The entire scope of private sector strategies – from health coaching to predictive modeling to customized care plans – are an integral part of the value beneficiaries receive through Medicare Advantage. These benefits are particularly important to the frail elderly and others with multiple chronic conditions.

In addition to improving patient care for chronic illnesses, the Medicare Advantage program also provides many additional benefits that are not included in the Medicare FFS benefits package. According to the Centers for Medicare & Medicaid Services (CMS), Medicare Advantage plans are providing enrollees with, on average, savings of almost \$90 per month – through improved benefits and lower out-of-pocket costs – compared to what they would pay in the Medicare FFS program. For example:

- **Protection Against Out-Of-Pocket Costs:** Many Medicare Advantage plans provide protection against high annual expenditures to ensure that the most vulnerable beneficiaries are not denied services because they cannot afford the cost-sharing required in the FFS program. In 2008, more than 99 percent of all beneficiaries have access to a plan that has out-of-pocket limits for the year of \$5,000 or less and 54 percent of beneficiaries have access to a plan option with out-of-pocket limits for the year of \$1,000 or less. Additionally, more than 99 percent of beneficiaries can select a plan with out-of-pocket maximums for inpatient hospital stays.

- **Alternative Cost-Sharing:** Medicare Advantage plans also put preventive benefits and physicians services within reach. Without Medicare Advantage, many beneficiaries would be required to pay 20 percent cost-sharing to go to the doctor or receive a pelvic or prostate exam. Medicare Advantage plans are readily available to almost all Medicare beneficiaries to ensure that cost-sharing is not a barrier to these needed services.
 - While traditional Medicare has a 20 percent co-insurance for primary care visits, many Medicare Advantage plans offer no or low co-payments. Sixty percent of beneficiaries have access to a plan with no cost-sharing for primary care visits, and almost 99 percent of beneficiaries can select a plan with \$10 or less as a co-payment for primary care visits.
 - Over 90 percent of all Medicare Advantage plans do not charge cost-sharing for screenings for prostate, pelvic, and breast cancer screenings.
- **Additional Benefits:** Medicare Advantage plans also often provide coverage for benefits not offered by FFS such as preventive eye and hearing exams. About 80 percent of all Medicare Advantage plans offer coverage for these benefits.

In addition, CMS has released findings¹⁸ showing that Medicare Advantage enrollees – when compared to beneficiaries with only FFS coverage – are less likely to report that they have no doctor, less likely to report that they have no usual source of care, and less likely to report that they have trouble getting needed health care services. CMS indicates, based on 2005 data, that:

- 26 percent of beneficiaries with FFS only reported they did not have a usual doctor, compared to only 8 percent of Medicare Advantage enrollees;
- 17 percent of beneficiaries with FFS only said they delayed care because of cost, compared to only 6 percent of Medicare Advantage enrollees; and

¹⁸ CMS, "Medicare Advantage in 2007," March 2007

- 7 percent of beneficiaries with FFS only said they had trouble getting care, compared to only 3 percent of Medicare Advantage enrollees.

Finally, I want to highlight the findings of a 2007 AHIP survey¹¹ regarding the important role Medicare Advantage plans play in providing health security to Medicare beneficiaries. According to this survey, 35 percent of Medicare Advantage enrollees – including 62 percent of low-income beneficiaries – said they would skip some of the health care treatments they currently receive if the option of choosing a Medicare Advantage plan was taken away. Another 42 percent said they would pay higher out-of-pocket costs if the option of choosing a Medicare Advantage plan was taken away.

The AHIP survey also found that 90 percent of beneficiaries enrolled in Medicare Advantage are satisfied with their coverage overall. Other findings show that a large majority of beneficiaries are satisfied with the quality of care they receive (93 percent), the number of doctors from which they can choose (92 percent), the benefits they receive (89 percent), the coverage they receive for preventive care (87 percent), their out-of-pocket costs (80 percent), and the coverage they receive for prescription drugs (76 percent).

V. Conclusion

Thank you for considering our perspectives on the Medicare Advantage program. We appreciate this opportunity to testify about the role health insurance plans are playing in providing Medicare beneficiaries with high quality, affordable, comprehensive health coverage. We urge the subcommittee to continue to support adequate funding for the system of competition, choice, and innovation that is delivering savings and value to nearly 9 million Medicare Advantage enrollees.

¹¹ National Survey Of Seniors Regarding Medicare Advantage, Ayres, McHenry & Associates, Inc. and The Glover Park Group, February 26 - March 2, 2007

Chairman STARK. Thank you.
 Dr. Lyons, were you guys in business in 1997?
 Dr. LYONS. Yes, sir.
 Chairman STARK. You were offering those same services to your members in 1997?
 Dr. LYONS. Some. Not all.

Chairman STARK. But you offered them? You offered the same kind of a program that you just outlined?

Dr. LYONS. We did not have our comprehensive Connections program at that time, Mr. Chairman. No.

Chairman STARK. How about in 2003?

Dr. LYONS. It was not as robust as it is today, no.

Chairman STARK. All right. Let me just run down the line. And I know you don't like to cheer for your competitors, but—and they are not really your competitors—but Pilgrim in Boston, Puget Sound in Seattle, Kaiser in California, Ford in Michigan, Marshfield Clinic in Wisconsin, would you say they are all similar to the kind of a plan you just outlined?

Dr. LYONS. I think they do. They are well-known for their quality, sir.

Chairman STARK. No. But they have the same general disease management and all of these things that—

Dr. LYONS. Many of them do. NCQA now certifies these kinds of programs and organizations. We all submit data to them.

Chairman STARK. And they were all chugging along in 1997, fat and happy at 95 percent of the AAPCC. And many of them, I am aware, operate at less than 100 percent of AAPCC. Why should we pay them any more?

Dr. LYONS. The investments that have been made in systems that aren't tied to delivery systems, systems that are more open or substantially more, it is much harder, actually, to engage physicians who aren't on your payroll, who actually aren't part of your delivery—

Chairman STARK. Well, not all of these guys have docs on their payroll. Kaiser does; it is a staff model. But not all of them do. Many of them operate as managed care plans, and they—well, I have trouble.

Are you familiar with what is referred to as boutique medicine, as provided generally by primary care docs?

Dr. LYONS. Is that where physicians opt out of the Medicare system and take—

Chairman STARK. Or if they are not in the Medicare system, they charge you maybe 1500 bucks and you get 24/7. You get their home phone and—

Dr. LYONS. You know, that sort of arose a few years ago. I haven't heard a lot of it recently.

Chairman STARK. Well, it could be done. When I go into Medicare, it will cost you taxpayers nine, ten grand a year. And so for 15 percent over, I could get a boutique and have a full-time—you know, just like the President or somebody else, or a movie star, have a full-time physician, basically. And I think that is great.

I just guess I have trouble figuring out why we would pay for it. And I would ask Dr. Thames. United Health Care basically is the insurer with whom you contract. Is that correct?

Dr. THAMES. Yes, sir.

Chairman STARK. And they sell a Medicare Advantage—they provide you the Medicare Advantage policy, and you put your name on it. And if I buy a membership, I can get it through you, but it is basically operated by United Health Care. Is that—

Dr. THAMES. You get it directly from them. We don't sell any policy.

Chairman STARK. And they don't offer the private fee-for-service plan, do they?

Dr. THAMES. That is absolutely correct, sir. It is against our policy to support private fee-for-service plans.

Chairman STARK. And I think that I recall in this conversation some time back that Mr. Novelli, your chief executive officer, said to me—and I don't think I am quoting him out of context or incorrectly; if I am, you should let me know and I will set the record straight—but that he felt that they should provide these plans at no more than 100 percent of fee-for-service costs.

Dr. THAMES. That is correct, Mr. Chairman.

Chairman STARK. So I think you are to be commended for that, and I am sure that—is Independence Blue Cross going private? Are you going to become for-profit?

Dr. LYONS. No, sir.

Chairman STARK. No?

Dr. LYONS. No. We are merging with Highmark Blue Cross.

Chairman STARK. And are they not-for-profit?

Dr. LYONS. They are also a hospital charter organization, just like we are.

Chairman STARK. You are going to stay nonprofit?

Dr. LYONS. Yes, sir.

Chairman STARK. Good for you.

Mr. Mattes, in your hospital, how many physicians have privileges there?

Mr. MATTES. We have 43 on our active medical staff.

Chairman STARK. Have you got a lot more in the community than that?

Mr. MATTES. No. That is the entire county.

Chairman STARK. That is kind of interesting. You have got 43 doctors and 21 plans.

Mr. MATTES. And only 25 beds in the entire county.

Chairman STARK. Do you need one plan for every two doctors?

Mr. MATTES. Well, I was thinking the same thing. Actually, we believe there will be more plans. We are aware of some that are being sold in addition to the 21 that have actually hit our door.

Chairman STARK. As I say, does it really offer a lot more choice in your what we will refer to as a rural community without demeaning you, I am sure—

Mr. MATTES. Well, there is choice in plans but not choice in providers, in reality, because we live in an isolated part of the State where they have to travel over a mountain pass.

Chairman STARK. I understand that. Does every plan let you have every doctor?

Mr. MATTES. Yes.

Chairman STARK. So if I signed up with any one of the 21 plans, I wouldn't be denied the opportunity to see any one of the 43 doctors?

Mr. MATTES. Well, I will take that back. One of our plans is a PPO plan. So that one has to have members signed up for—participating members in the plan. And I don't know whether all of them are signed up for that one or not.

Chairman STARK. I guess I wanted to ask Mr. Lipschutz, in California I know that we have attempted over time to deal with marketing. And I don't know what the restrictions on these types of policies—I don't know what you would call them, like AFLAC, where you get sick, you get 50 bucks a day. And those are the types of plans you are referring to that are sold under the guise of being Medigap. Is that—

Mr. LIPSCHUTZ. These Medicare Advantage gap plans that we learned about are essentially limited benefit plans that are bundled together, such as hospital indemnity plans, plans that will pay out—

Chairman STARK. But just help me here a minute. They don't offer anything but a fixed amount per day, regardless of what triggers it. Otherwise, it would seem to me they would come under the Medigap rules.

Mr. LIPSCHUTZ. Correct. It is our understanding that the current anti-duplication provisions in Federal law apparently allow the sale of these types of products—

Chairman STARK. Because all they offer is so many dollars a day?

Mr. LIPSCHUTZ. Pay a cash benefit, yes.

Chairman STARK. Pardon?

Mr. LIPSCHUTZ. They pay out a cash benefit when people incur expenses.

Chairman STARK. That is it. And then you can then spend the money any way you want. They don't send it right to the doctor or the hospital; they just send you a check for X bucks a day.

Mr. LIPSCHUTZ. Correct.

Chairman STARK. But I think what your testimony was saying, they are thinly disguised or suggested in the marketing approach that they are Medigap, as people remember buying it from AARP or Blue Cross or whomever. Is that a fair assessment?

Mr. LIPSCHUTZ. Based on what we have found in advertising, it looks like to beneficiaries it is pitched as just limited benefit plans that will pay out cash benefits when you need services. But to agents selling the plans, it is clearly pitched as a plan meant to fill in the gaps of Medicare Advantage and meant to be sold along with Medicare Advantage plans in order to fill in those gaps.

Chairman STARK. You are familiar with the California Insurance Commissioner's office?

Mr. LIPSCHUTZ. Yes.

Chairman STARK. And you have been doing what you have been doing under both Republican and Democratic administrations, when John Garamendi was insurance commissioner? I don't know who it is now, but—

Mr. LIPSCHUTZ. Steve Poizner.

Chairman STARK [continuing]. Do you find them to be pretty even-handed, pretty effective, pretty good at governing insurance agents and practices?

Mr. LIPSCHUTZ. As far as we can tell, yes. However, in the Medicare Advantage context—

Chairman STARK. Keep going.

Mr. LIPSCHUTZ. All right. I was going to say—

Chairman STARK. Let me ask the question. It sounded like—I have figured it out. But you go ahead. I know what you are—go ahead.

Mr. LIPSCHUTZ. Thank you. In the Medicare Advantage context, the jurisdiction of State departments of insurance is, by and large, limited to the regulation of insurance agents selling Medicare Advantage products, and the individual State departments of insurance have very little jurisdiction over the actual Medicare Advantage plans themselves and Part D plans.

Chairman STARK. Let me say it another way because Mr. Pomeroy would say the same thing and I think it is an important distinction here. CMS can regulate the plans, and CMS federally can fine Dr. Lyons' plan or United Health. But CMS can't—if Dr. Lyons company were to employ a broker, an independent agent—I don't know. Do you do that? I would presume—

Dr. LYONS. No. We have our own staff.

Chairman STARK. You sell all direct?

Dr. LYONS. Our employees—

Chairman STARK. You don't allow insurance brokers to sell?

Dr. LYONS. Yes. Within our market area, we only have our own staff.

Chairman STARK. Other Blues do, though. Other Blues allow brokers. And what I am trying to get at is the Federal Government has not ability—they can punish Dr. Lyons' plan, but they can't punish or regulate the individual independent brokers or agents.

And it is often the plans who have great intentions, but then they pay a commission to any sales person operating under State licensure who are very aggressive, probably good at what they do, but sometimes they may cut a few corners on explaining benefits and selling in the best interests of the consumer.

And I just wanted to see if you would agree that that would help us in California if somehow we could let the State commissioners who—at least in California, I think, and I am sure in Pennsylvania they do as well—regulate sales practices. And would that—it couldn't affect your plan. Correct? I mean, because you do it directly anyway.

Would it affect your plan, Dr. Thames, if the States in which you operate—

Dr. THAMES. Mr. Chairman, it could affect it in Florida. On the other hand, we don't allow all agents of United to sell AARP products. We have special requirements of the agents that sell those products. They are required to do outbound follow-up calls after sales—

Chairman STARK. Would it trouble you if the various State insurance commissioners were—

Dr. THAMES. No, sir. It would not trouble us at all.

Chairman STARK. I guess that is the point I was trying to get at—

Dr. THAMES. Yes, sir.

Chairman STARK [continuing]. Is that the companies can have the best intentions but can't often control the independent agents, certainly as you do. And that might be an advantage.

Thank you for your testimony. Mr. Camp, would you like to inquire?

Mr. CAMP. Yes. Thank you. I would agree that Mr. Pomeroy has a good point, and I spoke to him informally after he made his comments.

Dr. Lyons, you were beginning to sort of talk about the costs of engaging doctors not on your payroll. Could you just elaborate on that a little bit? I don't know that we got the complete thought there.

*Dr. Lyons. Thank you, sir. In order to set up systems of care, particularly systems that monitor quality of care and promote continuity of care, you either have to, A, have physicians who are aligned in a system because of contract economic incentives, or B, you have to put an infrastructure in yourself. And we have done the latter, and that is what many plans have done over the past five to six years, put in extensive infrastructures of quality management and care improvement, to act as sort of an overlay to the system to promote quality.

And if I may just briefly continue, there is no question that there is good evidence that this does work. We see sequential and statistically significant improvements across a wide variety of care outcomes. There is very limited opportunity to compare our care outcomes with fee-for-service, but when those comparisons have been made, for example in the well-cited study by Stephen Jencks in 2003. There was no question that Medicare Advantage plans in general produced better clinical outcomes than were extant in the fee-for-service system.

Mr. CAMP. All right. Thank you.

Mr. Mattes, you mentioned, I guess in response Mr. Stark's inquiry, that because there are 21 plans and they cover all your doctors, that they don't really negotiate much in terms of discounts. Yet in your testimony, you said Medicare Advantage carriers will use market leverage to force discounts in payment rates. And then you go on to say that those are provided to beneficiaries, but that hurts small hospitals such as yours.

But clearly, are they negotiating discounts and leveraging or are they not?

Mr. MATTES. Representative Camp, the comments in my testimony were prospective. We are not negotiating with any of those plans other than we have one PPO contract. However, it is my understanding that fee-for-service plans can, when they aggregate enough volume, initiate negotiations with providers. And our fear is that they will attempt to leverage us in those negotiations.

Mr. CAMP. So you are concerned that this is in the future. If this plan is allowed to continue, they will actually negotiate discounts for their beneficiaries in some fashion.

Dr. Lyons, can you briefly also explain in a little more detail some of the benefits your plan offers that traditional Medicare does not, and efforts in terms of coordinating care and wellness? If you could just comment on those, I would appreciate it.

Dr. LYONS. Yes. You are welcome, sir. I would sort of put them in three categories. At the front end are prevention and wellness services that are not provided to fee-for-service beneficiaries. This would be coverage for services that are needed to prevent disease, reminders and promotion of those services, and then a fairly broad array now of what we would call lifestyle modification programs—

smoking cessation, fitness. Probably our most popular benefit is our fitness program, free gym membership to seniors; and of course, obesity and weight management, currently the biggest epidemic.

And in the middle is a series of programs that are largely educational in nature, a fairly broad base. But they also allow members who do have specific conditions—we currently have developed clinical modules for 21 clinical conditions that actually have very intensive education and coaching, more serious events such as prostate cancer, breast cancer, and so forth and so on.

And at the third level, for folks who are actually engaged in a chronic illness and are significantly ill or disabled, we have much more extensive problems with extensive literature, one-on-one coaching, and so forth.

So that is kind of at the core. More recently, as we have tried to work with our delivery system and fill in the holes and gaps that we see, particularly around frail, elderly care are our homebound physician program.

Mr. CAMP. Thank you. And I don't mean to interrupt, but I am running out of time. But this comprehensive approach, is that successful in keeping patients healthy and out of the hospital? And if so, has that reduced cost?

Dr. LYONS. Yes. Both. It both improves clinical outcomes—we measure them regularly, we report them regularly, and we do have data that shows that there have been statistically significant reductions in both in- and outpatient care for the managed population compared to the non-managed population in each of the three and a half years since we launched our robust programs.

Mr. CAMP. And is traditional Medicare capable of offering programs like that?

Dr. LYONS. No. I don't see how the program could. I am privileged to serve on the Advisory Panel for Medicare Education, and I actually have chaired the panel the past two years. So I have a wonderful window seat to see all of the wonderful innovations that the fee-for-service program is bringing. But to get to that level would take substantially more investment, time, and a different approach.

Mr. CAMP. All right. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Ms. Schwartz, would you like to inquire?

Ms. SCHWARTZ. Thank you, Mr. Chairman. I appreciate it. And I thank all of the panelists. And I did want to start with, I guess, my own home-grown—not a constituent, I don't think, necessarily, Dr. Lyons, but—

Dr. LYONS. Almost. I am just over the line.

Ms. SCHWARTZ [continuing]. But I certainly wanted to talk about some of the things that you have talked about, and hopefully be able to talk a bit more about some of the private fee-for-service plans, which I know you are not talking about.

But I was interested in the fact that—I wonder if you could give us more information about some of the successes. I mean, you really talked—and many of us here, the only real statistics we end up hearing about the success of more managed programs and more prevention are really patient satisfaction, which is a piece.

That is fine. But really, I think one of the things we ought to be really concerned about is actually have we really improved out-

comes? Are people—their health status improved, actually? And are we doing it in a more cost-efficient way? That would be helpful to know. Do you actually have hard data on that and—well, why don't you answer that first. And then I wanted to know how much more it costs.

Dr. LYONS. Yes. Yes, ma'am, we do. We have data about all three of those arenas. So when it comes to—do the systems we use to promote prevention, do they work? And I would say the two major pieces of that are we actually measure and monitor and reward primary care physicians for superior performance in preventive care. So that would be programmatically what we do, number one.

And then number two, we have extensive outreach campaigns with members to promote the use. And we use a scientific survey. We report the data publicly. And there has been significant improvement from the times that we started the programs.

Also, if we do plateau, we gather clinicians and just, as an example, some years ago it was very clear that there just wasn't enough interest in the radiology community to provide basic mammography any longer. It just wasn't something they were—so we brought them together, brainstormed, and improved some access issues.

And so, yes, we can show you how that over time—

Ms. SCHWARTZ. I would be interested to see some of that hard data because otherwise really it's so much—you are not required, though, to give that to CMS or to the government?

Dr. LYONS. Well, actually, yes. We do report all of our clinical outcome studies via NCQA to CMS, and also via annual—including utilization data. I know that came up earlier. But we do provide utilization.

Ms. SCHWARTZ. There is a lot of utilization data we don't actually get. But again, utilization is different than outcomes. And that is something that we are really interested in.

Can you tell us how much more you get paid under the Medicare Advantage?

Dr. LYONS. Well, I am not an actuary, Congresswoman. But what I would say is that—

Ms. SCHWARTZ. Well, we know on average that nationally we are paying 12 percent more. Are we paying you 12 percent more for Medicare Advantage?

Dr. LYONS. We don't think so. No, no, we do not think so. Our actuaries do not think that the overpayment in our market basket, the five counties of Philadelphia, even approaches that much. And what we really focus on, because we are a legacy plan who have been out there for a long time, is really what happens year over year.

For example, in 2007, our payment increase from CMS was zero. It was flat. We got nothing, at a time when healthcare cost inflation in Philadelphia—which as you know is medically rich; it is really—

Ms. SCHWARTZ. Yes. We have great assets.

Dr. LYONS. We have great assets and high use of great assets. And so our—

Ms. SCHWARTZ. But you are saying you don't know how much more you get paid for Medicare Advantage than—

Dr. LYONS. No. As I say, our own studies think that it is a trivial difference, that the difference between Medicare fee-for-service, given a lot of the complexities and nuances about our payment stream, is very little different from fee-for-service beneficiaries.

And what we do know is that medical inflation in Philadelphia typically runs anywhere from 6 to 8 percent. And when that gap intrudes itself, we have nowhere to go with—

Ms. SCHWARTZ. Yes. But I am sorry. That is not the question I am asking.

Dr. LYONS. Yes.

Ms. SCHWARTZ. We actually have a President's budget that is not acknowledging any medical inflation at all. So inflation, medical costs, they are either flat funding or cuts. So that is really barely on the table. I mean, we are actually raising that as to whether that is reasonable.

But my real question is that you are providing these additional services—well, you actually didn't really say they were—well, some of them are services. But how much more does that cost you to do that? You can't tell us that, or you don't know it?

Dr. LYONS. I know what our administrative costs are. I do know that. As to the question of how our payment rates relate to the fee-for-service system, I don't have a specific answer. But I could certainly find out.

Ms. SCHWARTZ. One of the things we are obviously concerned about and interested in is that if we are paying—the public taxpayer is paying more money to get services to Medicare beneficiaries, to just some, about 20 percent of our beneficiaries, we want to make sure that we are using those dollars well—right?

Dr. LYONS. Very reasonable.

Ms. SCHWARTZ. And if in fact it is really very wonderful and working, then why doesn't everybody get advantage of this? And most of the Medicare managed plans—I am assuming you have said yours as well—is that you can do more for the same amount of money by managing it better, by being smarter, by being more efficient, by doing prevention. Right? And then they come back and say, we still need more money.

So it is kind of inconsistent. We are trying to figure out if there is a way to actually say if you really are saving lives and keeping people healthier, having better outcomes, then you are saving some dollars. So why do we actually have to pay you extra for that?

Dr. LYONS. I think, again, these are complicated questions. There are no simple answers to them. But my own perspective is that the system itself is very badly flawed. In other words, the overall healthcare delivery system—we are just a part of it.

But we operate with a much larger system, with all sorts of incentives that are not particularly well aligned with quality and accountability, all of which is very well documented in Institute of Medicine and other reports. So we are a bit swimming upstream doing the best we can.

Ms. SCHWARTZ. Well, I understand. Actually, I think you are being incredibly modest. For those who don't know, Independence Blue Cross has a huge percent of the marketplace in southeastern Pennsylvania and is a very big player in potentially making big differences in the creating incentives and the way we do things. So

I appreciate your modesty, but I'm not sure that it isn't true that you actually have a very big player in the field here and could actually be very much of a participant.

Just one other question. You really talked a lot about prevention. You know, we have been trying to incentivize through Medicare, traditional Medicare, more prevention, more primary care, and creating those same kind of incentives. We have actually had a real push-back from the administration about that and from the other side of the aisle as potentially not being a useful thing to do.

Would any of you think that that is not a smart thing, to actually be putting greater emphasis, more resources, on prevention and primary care?

Dr. LYONS. Congresswoman, I would put on my advisory panel hat for just a moment. I don't know, candidly, the administration's posture. I know at the panel meetings, we panelists have regularly heard from CMS staff about all the things they are doing to promote prevention, including systems that would actually somewhat mirror what we do, which is getting out at least reminders and so forth to folks, allowing you to set up sort of web-based personal health registries and so forth.

So I think they are making progress. It isn't anything such as what we have and are developing, but still I think important steps are being made.

Ms. SCHWARTZ. All right. I have many other questions, but I think my time is up. And I yield back.

Chairman STARK. Mr. Becerra, would you like to inquire?

Mr. BECERRA. Thank you, Mr. Chairman. And thank you to the witnesses for your patience and indulgence. We appreciate your being here.

Let me begin with Dr. Thames. It is Thames?

Dr. THAMES. Thames, yes.

Mr. BECERRA. Dr. Thames, thank you for being here. Private fee-for-service plans, I think you have heard a little bit of discussion about the private fee-for-service plans. I know there is a great amount of concern about the private fee-for-service plans, not only because of a lack of oversight, but because they seem to be providing a lot of offers but less in actual services and value for service.

And so I am wondering if you can—and if you have already answered this, I apologize—but does the AARP's plan that it uses with some of its private insurance company providers work with them to provide a private fee-for-service plan to its AARP members?

Dr. THAMES. Absolutely not. We have a policy, AARP presently and for a number of years, which is not expected to change, that says we do not support private fee-for-service plans. And we don't plan with our present provider to offer any such plans under Medicare Advantage or otherwise.

Mr. BECERRA. Now, and if you can do this briefly, give me an explanation. Because I think most seniors who are listening who may understand the difference between a fee-for-service traditional Medicare program, which they are accustomed to if they have been on it for a while, as opposed to a health insurance company product, Medicare Advantage, called private fee-for-service, they might

think they are getting the best of both worlds. They are getting fee-for-service but in a private setting.

And can you give a brief explanation of why you avoid using private fee-for-service plans?

Dr. THAMES. Yes, sir. I will try to keep it very brief. First, they are the highest paid of the policies, and again, our policy is for equity in payment, as MedPAC and others have recommended. So that is the first thing that would not qualify them.

Mr. BECERRA. And when you say paid, meaning government payments through Medicare for the insurance carrier?

Dr. THAMES. Eighteen percent more than they do for traditional Medicare. Secondly, they are not required to belong to quality improvement organizations, and we believe that that should be part—as it is for the other Medicare Advantage programs—a requirement.

Third, they are not required to do coordinated care, and we feel that is very important both in better medicine and lowering costs for medicine as a whole. And last—or perhaps one of the other reasons, at least; it may not be last—but at least one of the other ones is from what we have seen, most of the complaints that come in that we have looked at come from problems that are with private fee-for-service plans.

And again, another reason is we don't believe in balanced billing for people on Medicare programs.

Mr. BECERRA. So I thank you for outlining the Medicare Advantage problems with their private fee-for-service plans. Let me ask you this: As a doctor, if I needed to get a hearing aid, what is the average cost or what am I looking at in terms of a cost for a hearing aid?

Dr. THAMES. Well, you are looking at—and it is of interest that we are looking at hearing aids because so many of our people want those—you are looking at from something like Miracle Ear or something along that line for just a couple of hundred dollars to the best digital hearing aids that may cost you \$2500 an ear for those, so that that is definitely a very high cost item.

Mr. BECERRA. And so we are hearing more and more about some of these Medicare Advantage plans that are offering these wraparound packages or saying that they are offering a great deal of benefits if these seniors were to switch over from regular, traditional fee-for-service to the Medicare Advantage program.

And I have information here about a program in Michigan, a Medicare Advantage plan in Michigan, that lists for those who are thinking of switching over to their plan that it provides dental, hearing, and vision benefits in their plan. They say that in their plan summary, that they provide those benefits in dental, hearing, and vision, and that there are no co-payments.

Obviously, any senior hearing that—no co-payments; I go in, I don't have to fork over any money for going in for that visit or for that particular product. But then at the end of the explanation of benefits, at the very end, you read the following: "Dental, vision, and hearing benefits are part of the basket benefit. The basket benefit is capped at \$700 annually for all of these services."

And so in essence, what they are saying is that we offer you these benefits. You don't have to pay anything up front. But if you

don't finish reading this whole paragraph or this whole page, you won't notice that you only get \$700 worth of this. And so if you try to get a couple of hearing aids, you get the cheapest ones, you have already used up \$500 of your \$700 benefit. Forget about vision and contact lenses and dental, that who knows how much it will cost.

But is that the way that you allow any of the Medicare Advantage plans that you work with to market to your seniors?

Dr. THAMES. No, sir. As I indicated a little earlier, we have—the only agents for United who can offer our products are people who have had special training on selling those products and being completely honest, and fully disclosing to them, and have to take tests and pass those.

Secondly, they have to sign a code of ethics. And last, we do secret shoppers from AARP—not from our carrier, but from us—to ask our people and listen in to the sales pitch and see if they are really doing what they say they are supposed to do and what they have signed up to do.

And then, as I indicated earlier, after the calls, we have the outbound follow-up calls that we also require. So we have a limited number of agents within that company who do that, and we hope that we are going to have the highest quality standards in the business.

Mr. BECERRA. Mr. Chairman, I know my time is expired. If I could just ask Mr. Lipschutz one question, and that is: You have heard what Dr. Thames from AARP has said, that they undertake to do some oversight of these Medicare Advantage plans. Do all Medicare Advantage plans do that type of oversight?

Mr. LIPSCHUTZ. It is my understanding that no, most of them don't. And looking at the United Health plan that AARP has lent or sold its name to, other products under that umbrella have been a source of significant complaints in the field of marketing. For example, Secure Horizons products in California, they do sell private fee-for-service plans, and they are targeting dual eligibles in some areas that has resulted in significant harm to beneficiaries.

Mr. BECERRA. I appreciate it. Thank you, Mr. Chairman.

Chairman STARK. Welcome. I acknowledge the presence of our distinguished gentleman from Texas, Mr. Johnson. Would you like to add some wisdom to this, Mr. Johnson?

Mr. JOHNSON. Thank you, Mr. Chairman. I appreciate that. I don't know about the wisdom part.

Dr. Lyons, Independence Blue Cross provides physicians with information that compares their practice's ability to manage chronic disease against performance of their peers. Do you find that information useful, and do you believe other physicians can learn from those comparisons?

Dr. LYONS. Yes. Yes, sir, I absolutely do. We developed those reports with their input, and so we try to make sure at the front end, sir, that this is going to be useful information, that it won't be inflammatory, that it will be helpful to them, and actually help them give better care.

I don't practice any more. I did for many years. I practiced in a very rural community. And candidly, I would have loved to have gotten more information about care gaps so that I would have

known better exactly who was getting what and what they needed at the time of their care.

Mr. JOHNSON. Yes. That is good. Thank you very much. I am going to yield to Mr. Camp, if I may, some of my time.

Chairman STARK. Without objection.

Mr. CAMP. Thank you. Thank you very much.

Dr. THAMES, do you have information that you can make available to this committee about any concerns you have received from Medicare beneficiaries on any marketing and sales tactics used by AARP's Medicare Advantage plans? Have you got that information?

Dr. THAMES. I don't personally have it, Mr. Camp. I will certainly—and my staff people are here from AARP—go back and see, since we only began to have these programs since January. But I will be happy to provide any material that we have to the committee.

Mr. CAMP. And also, to help us evaluate the effectiveness of these plans and the satisfaction people have with these plans—

Dr. THAMES. Yes, sir.

Mr. CAMP [continuing]. If you have those sorts of complaints or any concerns about people that are in AARP's Medicare Advantage plan that maybe didn't realize they were in it or any of that nature. I think we are very interested in sort of the sales and marketing side of this as well.

Dr. THAMES. Yes, sir.

Mr. CAMP. And I think that is something we want to try to move forward with together.

I guess I would just say I appreciate all of your testimony. Thank you very much. Thank you, Mr. Chairman.

Mr. JOHNSON. Thank you, Mr. Chairman.

Chairman STARK. Well, I want to thank you. I wanted to explain to the witnesses that for a variety of procedural reasons, the House has finished, perhaps an hour ago, its deliberations, formal deliberations, for today, I guess for the rest of the week. And so many of our colleagues headed home to escape this wonderful weather. And I want to suggest to you that your testimony is appreciated. The efforts in getting here and your patience is appreciated.

And I hope, although each of you have some different approaches, that just to summarize, I think we could say to Dr. Lyons that all of us appreciate the many advantages that are possible under a coordinated, multi-discipline practice. And we appreciate groups that have the huge resources like AARP, as well as rural communities that wish they had more resources, and through modern technology and digital imaging may get the advantages of group practice over the internet and in other manners.

And then the consumer advocates like Mr. Lipschutz, who just offer tremendous help to congressional offices, who often hear these complaints or hear the bewilderment of seniors wondering what they now have and why they can't see the doctor they saw before, or why Kaiser is raising their rates so much. I don't suppose that Blue Cross does that, but you hear it.

And so what we are trying to do is figure out—on the one hand, we are hearing the clarion call that Medicare is going to go broke. And we have got to figure out how best to reimburse all the profes-

sionals who work hard to get the best quality we can. And your contributions to enlightening us in that direction are very much appreciated. I want to thank each of you for taking the trouble to be here and helping us.

And with that, the hearing is adjourned.

[Whereupon, at 1:04 p.m., the subcommittee was adjourned.]

[Submissions for Record follow:]

Statement of Association for Community Affiliated Plans

Chairman Stark, Ranking Member Camp, and Members of the Subcommittee, the Association for Community Affiliated Plans is pleased to submit a statement for the record to the Subcommittee on Health of the House Ways and Means Committee as you examine the cost and value of Medicare Advantage plans.

ACAP is a national trade organization representing 37 non-profit safety net health plans that serve more than 4.5 million Americans in Medicare, Medicaid, and other public health programs. Nineteen of our ACAP plans operate Special Needs Plans (SNPs) as an integral part of their mission. SNPs can assure continuity of care to dual eligibles who may be served by the plan through a Medicaid contract with the State or who were enrolled with the plan immediately prior to their Medicare eligibility.

We have watched as your committee addresses the very compelling issues of cost, benefits and marketing practices within the Medicare Advantage program. We wish to call your attention to a report, Medicare Advantage Special Needs Plans/Six Plans' Experience with Targeted Care Models to Improve Dual Eligible Beneficiaries' Health and Outcomes commissioned by Association for Community Affiliated Plans and prepared by Avalere Health.

The executive summary is attached to this testimony

Avalere studied six not-for-profit Medicare managed care health plans across the country that entered the SNP insurance market over the last two years. The report consists of case studies of six not-for-profit, community-based SNPs and documents the variety of ways in which these plans use highly tailored strategies and focused care models to provide benefits that go beyond traditional models of insurance for dual eligible beneficiaries. SNPs in the study include Affinity Health Plan, CareOregon, Community Health Plan of Washington, Denver Medical Health Plan, Mercy Care, and Neighborhood Health Plan of Rhode Island.

Some of the innovative services provided by these health plans include:

- Assignment of patient navigators who are dedicated to helping coordinate the complexities of Medicare and Medicaid benefits,
- Deployment of intensive, high-touch medical case management programs for those at highest clinical risk,
- Links to community services that address homelessness, hunger, and other non-medical stressors that can often lead to poor health outcomes and increased healthcare costs if left unaddressed, and
- Enhanced benefit designs that help cover dental care or other services that neither Medicaid nor Medicare cover but can contribute to decreased health.

The report demonstrates that the SNP designation served as a catalyst for these non-profit, Medicaid-focused plans to develop coordinated benefit models for dual eligible beneficiaries already served by Community Affiliated Plans for their Medicaid benefits. These plans are uniquely situated to integrate care under the Medicare and Medicaid programs.

You have heard from people appearing before your committee that what works for enrollees is when the right plan with the right incentives is available. We believe that mission focused plans with strong experience in serving low income beneficiaries can be that "right plan".

We would be happy to answer any of your questions about how we serve Medicare dual eligibles or have a member plan present to the committee.

ACAP Member Plans with Special Needs Plans

Affinity Health Plan (NY)
Alameda Alliance (CA)
CalOptima (CA)
CareOregon (OR)
Care Source (OH)
Colorado Access (CO)

Commonwealth Care Alliance (MA)
 Community Health Plan (WA)
 Contra Costa Health Plan (CA)
 Denver Health Medical Plan (CO)
 Health Plan of San Mateo (CA)
 Horizon NJ Health (NJ)
 LA Care (CA)
 Neighborhood Health Plan of Rhode Island (RI)
 Santa Clara Family Health Plan (CA)
 Virginia Premier (VA)
 University Family Care (AZ)
 UPMC For You (PA)

Executive Summary

Congress authorized Special Needs Plans (SNPs) through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to encourage health plans to develop targeted programs to more effectively care for high-risk beneficiaries. Plans have the statutory authority to limit enrollment to one of three special needs populations: beneficiaries dually eligible for Medicare and Medicaid, institutional beneficiaries, and those suffering from severe or disabling chronic conditions. Since the program's inception, the number of SNP plans and the aggregate SNP enrollment has grown dramatically, to over 477 plans with more than 1 million enrollees. This growth has attracted the attention of policymakers and raises questions about the value of the program and the ability of these plans to design and deliver programs that meet the unique needs of special needs individuals.

SNPs serving beneficiaries eligible for both Medicare and Medicaid (dual eligibles) have attracted particular attention, as these plans make up the majority of SNPs and have the highest aggregate enrollment. The characteristics of this population demonstrate that it is a population with special needs. Compared to the non-dual Medicare population, dual eligible beneficiaries are sicker, report lower health status, have lower functional status, and are more likely to be disabled. Medicare spending on a per capita basis is considerably higher for dual eligible beneficiaries (\$10,884) than Medicare spending for non-dual eligible beneficiaries (\$5,975).

This report focuses on how six not-for-profit, Medicaid managed care health plans are using the SNP authorization to serve dual eligible members through focused programs that are tailored to meet their needs. The case study plans are diverse and vary by geography, plan size, and relationship to Medicaid programs. Despite this variation, all of the plans invest across four key dimensions that they deem as critical to serving this population, including:

- **Coordination of the Medicare and Medicaid Benefit.** All plans coordinate the Medicare and Medicaid benefit and have staff dedicated to helping members navigate Medicare, Medicaid, social services, and the health system. These plan staff, often called patient navigators or Medicare advocates, serve as a single point of contact for members and assist with Medicare and Medicaid eligibility, Medicaid waiver eligibility and applications, obtaining medical appointments, securing transportation, and other member needs. While not all plans are in states that have dual eligibles enrolled in Medicaid managed care, all plans perform this coordination function, relying on their Medicaid plan experiences and relationships to do so.
- **Intensive medical case management programs.** Both the composition of the care teams and the method of interaction with members are tailored towards the special needs of this population. Case managers and/or care teams may include social workers, pharmacists, and other disciplines as well as registered nurses (RNs). The health plans rely on a high-touch model, which provides frequent contact between plan staff and members to educate patients on their condition, address member concerns, monitor health status, and identify healthcare needs.
- **Links to Community Social Services.** The six case study plans also link members to key community and social resources to address the non-medical stressors caused by poverty that often lead to poor health outcomes and increased healthcare costs if left unaddressed. Plans believe that linking members with essential social service supports that address needs such as homelessness, hunger, and lack of heating is critical to members' ability to participate in their own healthcare. The plans leverage their experiences with low-income populations and community social service providers to understand member needs and connect them with appropriate social service networks.
- **Benefit Design Plans use their Medicare supplemental dollars to fund enhanced care coordination services to help members navigate the healthcare system.** In

addition, they use these supplemental dollars to eliminate coverage gaps, such as dental care, that neither Medicaid nor Medicare may cover.

The six health SNPs profiled in this report are employing new models of care to better identify, treat, and manage the healthcare needs of persons dually eligible for both Medicare and Medicaid. As Congress and the Centers for Medicare & Medicaid Services (CMS) look to promote innovative models to serve high-risk populations such as dual eligibles, these case studies suggest that SNPs that have programs to meet the social and healthcare needs of the population hold promise of improved access, quality, and reduced costs.

Currently, Congress and other policymakers are examining the SNP program, and they are considering additional requirements to ensure these plans are truly meeting the needs of special needs individuals. Stronger requirements and criteria may contribute to greater consensus around the role of SNPs in providing tailored services to these populations. The SNP designation provides an administrative vehicle for policymakers to set and expect high standards for plans serving special needs individuals. Such standards can also serve to inform the current CMS and National Committee for Quality Assurance initiative to develop quality measures for SNPs that reflect the population and measure plans' success at improving access and quality and reducing costs.

Statement of Cathy Roberts

My name is Cathy Roberts and I am a senior paralegal here at Empire Justice, a statewide non-profit law firm focusing on poverty law issues. I work in our Medicare Part D (prescription drug) advocacy project, which provides backup training and support on Part D and related issues to advocates assisting dual eligible Medicare beneficiaries in upstate New York and on Long Island, including local SHIP (State health insurance program) counselors and legal services offices. We have been conducting an ongoing assessment of available services and unmet needs on Part D issues in communities throughout New York State.

Our message to the Committee is that that Medicare Advantage plans are particularly problematic for our dual eligible population in New York State. We will focus on two specific areas of special concern—marketing abuses and cost-sharing for dual eligibles.

Marketing abuses

One issue that keeps coming up among our advocacy network is continued marketing abuses of Medicare Advantage (MA) plans, especially among Private Fee For Service (PFFS) plans. Despite heightened enforcement and outreach on the Federal and State levels, as well as an aggressive public education campaign by State and local government agencies, illegal MA marketing practices continue to victimize seniors in New York State.

For example, our SHIP in Broome County has worked with dozens of seniors in Binghamton and surrounding areas who received “cold call” visits from an insurance agent selling MA PFFS plans during the fall of 2006 and early 2007.

Many of these seniors were pressured into purchasing MA PFFS policies because of misleading sales tactics on the part of the insurance agent. The SHIP filed a series of complaints with the State Insurance Department and in January 2008, the Insurance Department revoked this agent's license. The Insurance Department also issued a press release warning seniors to be particularly cautious of high-pressure or misleading sales practices during the MA open enrollment period.

We were hopeful that this publicity would have halted or significantly reduced the incidences of improper MA PFFS marketing practices in Broome County. Unfortunately, the local SHIP has continued to receive a steady stream of calls from seniors who have been misled by *other* insurance agents into purchasing MA PFFS plans. During the most recent influx of calls, the SHIP learned that seniors signed up for MA PFFS plans after being erroneously told by an insurance agent that “if you have Parts A, B & D of Medicare, but not Part C, you don't have a complete Medicare package.” The agent(s) had not made clear that enrolling in Part C meant *losing* their original Medicare coverage under Parts A & B. Once the seniors understood the full implications of enrolling in the MA plan, they wanted to disenroll. The Broome County SHIP office has been helping these folks disenroll and get back into original Medicare.

During discussions with the Broome County SHIP, the SHIP stressed that while there are many MA plans who provide good customer service and strive to abide by CMS' marketing rules, the damage done by the “bad apples”—agents/brokers

conducting improper home visits to market MA PFFS plans—is considerable. Seniors on limited incomes are pressured into obtaining MA coverage they don't want or need; the coerced MA enrollment results in a disruption of medical care or payment for services (because many times seniors learn after the fact that their doctors do not participate in the MA PFFS plan); and it takes significant time and energy to help these seniors straighten things out.

Unfortunately, improper MA marketing practices are not limited to Broome County. We have learned of these practices occurring throughout upstate New York—including Jefferson and Niagara counties—and in New York City, and some of the victims have been dual eligibles. Dual eligibles are particularly vulnerable to MA marketing abuses since their Low Income Subsidy status allows them to enroll in, drop or switch MA plans on a monthly basis, not just during the annual open enrollment period.

While the steps taken by CMS to crack down on MA PFFS marketing abuses have been helpful, the problem is so pervasive that a more sweeping solution is needed.

Cost-sharing issues for dual eligibles

Some dual eligibles enrolled in MA plans are being improperly charged for co-pays that should be picked up by their Medicare Savings Program or by Medicaid. We have only recently started to hear about this problem, probably because more dual eligibles are enrolling in MA plans. It is an extremely complicated and time-consuming issue to address on an individual case basis there are different cost-sharing responsibilities among the various categories of dual eligibles. So for an individual beneficiary you must:

- figure out the beneficiary's dual eligible status (are they QMB, SLIMB, QI-1? Do they also have Medicaid?);
- assess the State's cost-sharing liability using the CMS cost-sharing matrix;
- if the State is responsible, go back to the plan and the person's medical providers and advocate to get them to follow the proper billing procedures, which may require the filing of an appeal or grievance on the client's behalf and/or require CMS intervention.

These are steps that require fairly extensive knowledge of Medicare and Medicaid as well as considerable advocacy skills. How do we expect our disabled and elderly beneficiaries to be able to navigate through all this?

The dual eligibles with the lowest income—QMBs (with or without Medicaid)—are not supposed to have any cost-sharing liability in Medicare Advantage plans. However, the reality is that some of the poorest dual eligibles are being charged for services provided through an MA plan when they shouldn't be—at the same time that the MA plan is being reimbursed at a higher rate than original Medicare.

Conclusion

Medicare Advantage participation poses unique challenges for our dual eligibles, and the improper marketing abuses of MA PFFS plans and the inappropriate billing of dual eligibles cause significant harm to this very vulnerable population.

Statement of Representative Kathy Castor

I would like to thank Chairman Stark and members of the Ways and Means Subcommittee on Health for the opportunity to submit my testimony on Medicare Advantage for the record. It is no secret that Medicare Advantage marketing abuses have affected many seniors both in my district and the country as a whole. Reports from the Government Accountability Office highlighting the failure of the Bush Administration to adequately audit Medicare Advantage providers show that the time has come for legislative action. New standardized regulations are required or these forms of abuse will continue.

Too often we find that Medicare beneficiaries choose to participate in private Medicare Advantage plans without fully understanding their choice and its potential consequences. Often, beneficiaries are not made aware that the decision to choose Medicare Advantage is a decision to give up traditional Medicare. We have heard of instances when beneficiaries continue to send in their Medicare supplement premium for several months after they've signed up for a Medicare Advantage plan, never having been told that they are no longer responsible for that payment.

Seniors also transition to Medicare Advantage without warning that they may no longer have access to their current doctor. It is common for patients to inadvertently sign up for private Medicare Advantage plans that cost more in out-of-pocket expenses after being misled about which doctors accept the plans. In many cases,

there may be just a few if any doctors that accept such plans. Other stories include signing up seniors with dementia or using scare tactics such as "Medicare is going private," and they will lose Medicare or Medicaid if they do not sign up.

Many seniors are also not aware of their rights or ability to leave Medicare Advantage. Those who are aware and make the decision to return to traditional Medicare are forced to enter a complicated lengthy process that can adversely affect the delivery of health services and leave them without Part D coverage.

My home State of Florida has a large population of seniors. The marketing practices and abuses by private Medicare Advantage insurers are acute in Florida. Individuals in my own district have suffered marketing abuses under Medicare Advantage. Charleen Edge was enrolled in a private HMO that she neither requested nor desired. She tried in vain several times to switch back to regular Medicare. After breaking her pelvis last April neither Medicare nor the HMO would pay her bills. As a result, she is burdened with \$30,000 in debt. William DiPietrantonio, 73, of Tarpon Springs, signed up for the Universal Health Care plan called, 'Any, Any, Any' with the belief he would be able to see any doctor or go to hospital he wanted. When he learned that he could not, he attempted to switch back to traditional Medicare. An entire month passed before he was finally reenrolled in traditional Medicare. During this month, he accumulated \$15,000 in hospital bills for his chemotherapy treatments for lymphoma.

Without regulation, seniors will continue to suffer. My recently introduced legislation, H.R. 4790, the Accountability and Transparency in Medicare Marketing Act of 2007, will hold Medicare Advantage providers liable for their abuses and will make such abuses publicly known. This legislation requires the National Association of Insurance Commissioners (NAIC) to develop standardized marketing practices. It prohibits certain activities such as cross-selling of products. Under this legislation, the NAIC must establish a committee to study and make recommendations to the Secretary of HHS and Congress on the establishment of standardized benefit packages and their regulation. As CMS has largely abdicated its oversight responsibility, it is now imperative for Congress to protect America's seniors.

I would like to again thank Chairman Stark for this opportunity. I commend the Committee on Ways and Means and the Subcommittee on Health for holding hearings on Medicare Advantage. It is with great anticipation that I look forward to future hearings and opportunities to address this vital issue.

On behalf of the approximately 1.2 million members of The Senior Citizens League (TSCL), a proud affiliate of The Retired Enlisted Association (TREA), thank you for the opportunity to submit a statement regarding the need for accountability and oversight of marketing and sales by Medicare private plans. TSCL consists of active senior citizens, many of whom are low income, concerned about the protection of their Social Security, Medicare, and veteran or military retiree benefits.

While TSCL fully understands the need to address the looming Medicare Trust Fund exhaustion, we are also concerned with the complexity and plethora of private Medicare plans. It has been widely reported that many seniors have been misled and in some cases fraudulently signed up for a plan by insurance representatives. TSCL has been encouraged that the 2009 Budget proposal by the President's Administration included improved program integrity that could strengthen the Medicare entitlement program.

Unfortunately, TSCL has received a number of emails and comments from many seniors who have wound up in private health plans only to belatedly discover unexpectedly high costs. Often, they did not understand that they were leaving the traditional Medicare when they signed up.

Senate investigators have learned that insurance agents in at least 39 States used illegal or unethical tactics to sell private Medicare health plans, known as Medicare Advantage plans. Some insurers signed up unwitting consumers by using "bait and switch" tactics, forging signatures, using personal information stolen from Federal records, and even by submitting applications for deceased individuals. *The New York Times* reported that Albuquerque cancer specialist, Dr. Barbara L. McAney, said that many of her patients who signed up for such plans "suddenly found that they had huge new co-payments \$1,250 every three weeks for a combination of five intravenous chemotherapy drugs."

Agents of the private plans have worked out of booths in discount stores or tables set up in front of grocery or drug stores. Seniors might have thought they were signing up to get drug coverage or just more information. Then, if they required hospitalization or other costly services later, they might learn that there were higher co-payments than normally would be charged under traditional Medicare.

Enrollment in Medicare Advantage plans has exploded in the past year with one out of five Medicare beneficiaries enrolled. According to the Medicare Payment Advisory Commission, however, the government pays the private plans 12% to 19% more than it would cost Medicare to serve the same people. The non-partisan Congressional Budget Office estimates that the cost for these extra payments will amount to \$65 billion over the next five years. These extra payments are passed on to the nearly 80% of Medicare beneficiaries not enrolled in a Medicare Advantage plan in the form of higher Part B premiums and who receive none of the promised additional benefits provided by the plans.

Also many advocates are worried that the plans tend to siphon off younger and healthier seniors. TSCL's Medicare policy analyst found that this appears to be true based on the plans she evaluated during last November/December's Open Enrollment. Those plans were set up in a way that would have most benefited those who were young and healthy, and would have been cost-prohibitive for older seniors who might need a prolonged hospital stay. Because the plans receive higher payments than traditional Medicare and the young and healthy individuals are less likely to need to use many services under their plans, it contributes to raising the cost of Part B for everyone.

The Medicare Rights Center (MRC) has reported that there are common problems people have in Medicare Advantage plans. Unfortunately, many people discover these flaws after they have joined the plan and cannot switch until the following year. Problems can include:

- Care that costs more than it would under traditional Medicare.
- Difficulties in getting emergency or urgent care and care away from home.
- Choice of doctor, hospital and other providers is restricted.
- Promised extra benefits can be very limited.

TSCL is also highly concerned that the Centers for Medicare and Medicaid Services (CMS) have not been providing strong oversight of the private plans as required by law. Last fall, the Government Accountability Office (GAO) said that private insurance companies participating in Medicare have kept millions of dollars in Federal subsidies that should have gone to seniors to help lower premiums and co-insurance costs. The GAO also reported that CMS did not properly audit the companies or try to recover the money. Under Federal law, Medicare officials are supposed to audit the financial records of at least one-third of private Medicare Advantage insurers annually. The GAO said that CMS had never met the "statutory requirement."

At the same time, however, CMS was vigorously pursuing money that it says was owed to insurance companies by Medicare beneficiaries. In most cases, the premiums were supposed to have been withheld from monthly Social Security checks, but the government withheld the wrong amounts or nothing at all.

Conclusion

Although we are pleased that Congress is addressing the growing problem of private plan marketing abuse and while we do not have a perfect solution, there are some simple actions that could be taken in the meantime.

Tougher enforcement and increased transparency will save Medicare billions of dollars annually. **A significant portion of expenditures comes from fraud and abuse that hurts the solvency of important entitlement programs like Medicare for current and even future retirees.** When Medicare has had the investigative staff and tools required to combat fraud, about ten dollars for every one dollar invested has been saved in the past.

TSCL also supports lowering payments to the Medicare Advantage plans thereby making them equal to traditional Medicare plans. Preventing door-to-door sales of Medicare Advantage plans, stopping marketing abuses, and encouraging all Medicare participants to seek assistance from an unbiased, Medicare benefits counselor are seemingly simple steps that can be taken to protect beneficiaries and the future of Medicare.

Regardless of which solution Members of Congress believe is best, The Senior Citizens League sincerely hopes that the Medicare and Social Security Trust Funds are protected and strengthened for future generations.

Thank you.

